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VOL. II.—3RD YEAR—No. 25. SYDNEY: SATURDAY, DECEMBER 16, 1916.

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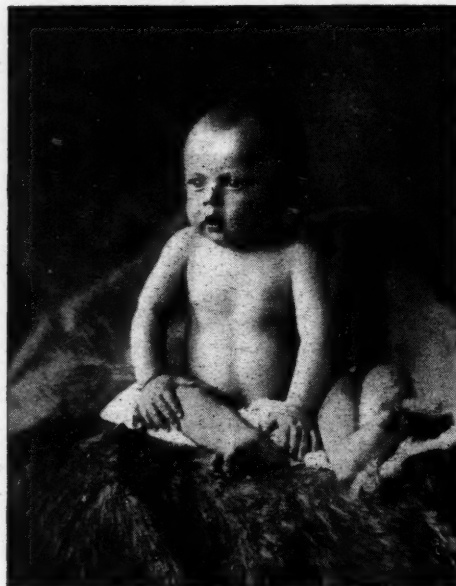
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# **VIROL**

# THE MEDICAL JOURNAL OF AUSTRALIA.

VOL. II.—3RD YEAR.

SYDNEY: DECEMBER 16, 1916.

No. 25.

## Presidential Address.<sup>1</sup>

Delivered by

A. V. M. Anderson, M.D.,

*Retiring President, Victorian Branch of the  
British Medical Association.*

At the termination of my year of office I wish in the first instance to express my appreciation of the consideration and courtesy extended to me by the Council and members during the year. It was with no small amount of trepidation that I accepted the position of President, but my duties have been much more pleasant and less onerous than I anticipated. My thanks are specially due to our former Honorary Secretary, Dr. Latham, who worked energetically and tactfully in the interests of the Branch, to his successor, Dr. Hooper, who has been equally helpful and efficient, and to Mr. Crouch, whose knowledge of and attention to the affairs of the Branch have been of the greatest service.

May I, Sir, offer you and the Branch my hearty congratulations on your accession to the presidential chair. Your scientific attainments, your patriotism, and your genius for organization specially fit you to fill the position to which the unanimous vote of the members has called you.

The annual report has referred to the losses the Branch has sustained by the deaths of many members, but there are two of these that require more than passing notice. Dr. James Jamieson was intimately associated with the scientific practice of medicine in this State, and was long and closely connected with the Victorian Medical Society and the Melbourne Medical School. Those of us who had the privilege of listening to his lectures in our student days realized that they were models of what such lectures should be. His scholarship and his knowledge of English and foreign medical literature enabled him to present up-to-date facts and theories in the most interesting way, and his personality appealed to his friends and colleagues as that of an honest searcher after truth, who required proof before accepting any new theory or any not well ascertained fact. His qualities gained for him the respect and esteem of all who had an intimate acquaintance with him.

Dr. F. Miller Johnson was known to his colleagues as a practitioner of the highest type. He was an enthusiast in his work and an able and conscientious physician. In the Council he gained the reputation of a man of energy and of sound judgement. Those of us who heard his valedictory remarks before going to the front will remember them as indicating the fine feeling of patriotism and high honour by which he was actuated. I am sure that no better end could have been wished for by him than that which came to him while helping his fellow-country-

men, who, like himself, were among the first to offer their services to the Empire of which he and they were such worthy citizens.

## The War.

The shadow of the great war in which we are all more or less participants has been over us during the past year, and necessarily the scientific work of the Branch has suffered from the absence of so many of our ablest and most energetic members. Although the ordinary work of the Society has thus diminished, the work done by the Council has been as voluminous as ever, and here again the alterations brought about by war conditions have been to a large extent responsible for this Council work. One of the lessons impressed upon us by the war is that, as medical men, we are an integral part of the Commonwealth, and as such we have a definite duty to our country. It has been the aim of the Branch and the Council to co-operate in various movements which have for their object the greater efficiency of the military medical service. It seems certain that, in future, organization to this end must be much more complete and widespread than it has previously been. Under present conditions one of the main difficulties has been to provide for the requirements of the civil population, while rendering the necessary assistance for military service, and the organized efforts by the Victorian Branch in this direction, largely prompted by our President, have been of much value, and have earned the appreciation of the military authorities.

In speaking of military medical service, we must not forget the claims of the sister Naval Service; we must realize that in our island continent our defence is primarily in the hands of the Navy. Hitherto we have been content to rely largely on the assistance of the Navy of the Mother Country; but a beginning has been made with the building of our own fleet, and a special medical service must be provided by the profession in Australia for that branch. Fleet Surgeon Bean has been commissioned to organize this work, and I hope he will have the whole-hearted support of members in his endeavours to secure the highest efficiency for his branch of the defence service. Much has been done by the profession for the medical needs of Australian soldiers and sailors. I hope that relief from active service for those of our members who have been on duty for the last year or two will be readily forthcoming when required.

In what direction future organization for defence purposes will take it is impossible to forecast, but that sacrifices even in time of peace will be required from us is certain, and it is probable that a larger permanent body of military and naval medical officers must be ready to form the nucleus of a larger war-time service. Those of us who have been taking part in medical work for our soldiers realize the great differences that there are between civil and military medical practice and the necessity of training for the work of examining those offering for

<sup>1</sup> An Address delivered at the Annual General Meeting of the Victorian Branch of the British Medical Association on December 6, 1916.



combatant service and for the treatment of those who have been more or less disabled by the medical and surgical disabilities incident to military service. The careful selection of recruits and the proper estimation of those disabilities which militate against efficiency as a soldier have been shown to be matters of very great importance. The stress and strain of warfare has familiarized us with a number of conditions that previously had not been brought so prominently under our notice. The proper treatment of these conditions calls for special training and considerable specialized experience, and one cannot help thinking that the war has vindicated the position of the specialist acting in collaboration with the practitioner, who is called in the first instance to the patient's aid.

#### The Use and Abuse of Alcohol.

One of the most interesting developments of the war is the question of efficiency as related to alcohol. The drastic steps taken in allied countries, such as Russia, to limit or prevent the consumption of alcohol during the continuance of the war will be fresh in your minds. In June of last year a resolution was passed by the Council to this effect:—

It is impossible to over-estimate the value of example, especially if it be set by the whole of the members of a humane and learned profession, and the Council believes that it is thoroughly justified in asking all its members, who are willing and physically able to do so, to pledge themselves to abstain from the use of alcohol during the continuance of the war.

The Council further very strongly urged its members to set an example by adhering to the above resolution. The advice of the Council had been very generally followed, at least on public occasions, and certainly with no detriment to the success and enjoyment of our gatherings. It is difficult to see that such an example would be any less valuable if it were continued after the war is over. Very many instances occur which show the general tendency of members of the profession to abstain more and more from advising the use of alcohol in sickness. In many hospitals the average cost per patient of alcohol is less in shillings than it was in pounds twenty years ago. We all know the physical ruin and mental degradation caused by excessive indulgence in alcohol and the diminution of resistance to infection and to the effects of injury brought about in the same way. We know too how often the drift from the moderate drinker to the alcoholic occurs, and it would seem to require very strong evidence of the benefit of alcohol under the ordinary conditions of life to sanction its use as a common beverage. Even as a medicine its employment should be advised only under the most carefully-considered restrictions and necessities. While one may admit that the ideal state of affairs is one in which the moderate use of stimulants is allowable, it seems that, until the controlling influence of self-restraint is much more strongly developed in the population generally than it is at present, it is wise to regard even the moderate use of alcohol as unnecessary and prone to give rise to possibly most serious results. If this be so, all measures which tend to reduce its

consumption and to educate the young especially as to the exact scientific knowledge which we possess of the effects of alcohol merit the support of the profession.

#### Venereal Diseases.

Somewhat allied to the alcohol question as a cause of diminished efficiency, not only in the army, but in the nation, is that of venereal diseases. The attention drawn by many members of the profession, especially by Sir Harry Allen, to the prevalence and disastrous consequences of these diseases has given rise to many suggestions as to the best means of controlling the evil. It seems to some that one of the most important is that of dispelling the ignorance that exists as to the nature and evil effects of these diseases. Not less important is a proper understanding of certain physiological facts, which must sooner or later obtrude themselves upon the notice of the adolescent. Ignorance as to such matters is apt to have disastrous consequences, and the ill-effects that may follow on misguided youthful passions are surely such as to overshadow completely any evils arising from occasionally imperfect or unsound teaching. Members of the profession might with much advantage co-operate with educational authorities and parents' unions in endeavouring to provide such instruction as should be at once efficient, scientific and free from any suggestion of immodesty. Education on these matters, however, should not, for the present at least, be confined to the adolescent; many of a more advanced age are woefully ignorant of the possibilities of venereal diseases on the individual and on the race. Whether such education should be effected by literature, lectures, the stage, etc., is a matter worthy of professional consideration. The introduction (first in the West Australian Parliament and more recently in our own State Assembly) of a Bill dealing with the prevention of venereal diseases marks an epoch of much importance in the history of legislative enactment. In so far as it is intended to safeguard the public health, the principle of compulsory notification is surely as justifiable in syphilis as in small-pox, as is that of the punishment of any sufferer who wilfully spreads the disease. The profession as a whole is in favour of this legislative Act, as the benefit to the people generally which is likely to be brought about by the provision of facilities for early and efficient treatment outweighs the possible pecuniary disadvantages to members of the profession. The necessity for a medical examination as a preliminary to legal marriage would seem to be a corollary of the Act, and suggests a further measure to make a clean bill of health a preliminary to all marriages. As a profession which is liable to so much unrestricted competition with unqualified and untrained practitioners of various kinds, it is of interest to remember that the Bill prohibits under heavy penalties treatment of sufferers from these diseases by other than qualified practitioners. It seems but a little step to the prohibition of treatment of all infectious diseases by quacks. Such treatment is still legally permissible in this and other States, disastrous as the results have been shown to be in various instances, not only to the person affected,



but also to the public, who are not sufficiently protected against infection.

#### The Profession and the Public.

Such questions as these, however, are likely to be relegated to that indefinite period which is known as "after the war," and it is probable that at or before that time other questions of as much importance will loom largely on the medico-political horizon. One of these, in all probability, will be that of some form of nationalization of medicine. What form this will take is doubtful; but it must inevitably affect the work and prospects of the profession very largely. It is interesting to recall the action taken by the parent Association in regard to this question. Just before the present British National Insurance Bill was first introduced, the Council of the British Medical Association, at the instigation of the annual Representative Meeting, in 1909, referred the matter to a sub-committee, which brought up an elaborate report, and from this report I quote the following passages:—<sup>1</sup>

There is a strong and growing demand from the public for the better provision of medical attendance for the wage-earning classes, and the extent and nature of this demand calls for the careful consideration of the medical profession. . . . It is clear that a large proportion of the community does not obtain that proper and efficient attendance which it is to the interest of the community that they should receive, that persons who, were the necessary organization in existence, could afford to provide by insurance for the cost of medical attendance have not at present the facilities which would enable and encourage them so to do, and that not only are the medical practitioners engaged in these various services underpaid for their work (a circumstance in itself detrimental not less to the public interest than to that of the profession), but much of it has to be performed under conditions which do not bring out the best service of which they are capable.

The profession must be prepared, therefore, for the possibility of action being taken in some form by the community, whether with or without the sympathetic co-operation of the profession, or even in disregard of the profession, which may profoundly modify existing conditions of medical practice among the wage-earning classes. . . . Public opinion increasingly demands that adequate medical attendance shall be placed within the reach of all members of the community, not only in the individual interests but also in the general interest. Public opinion will also prefer that those who are able to pay the cost of their own medical attendance should be encouraged or even compelled to do so.

It is true that these remarks do not apply with such force to Australia as to the British Islands; the amount of wages earned, and, consequently, the ability to pay for medical attendance is greater here than in the Mother Country; but still the remarks do apply in a less degree. The Friendly Societies certainly supply the needs of a large proportion of the wage-earning classes, and sometimes of a small proportion of the better off; but they leave a large number of the less well off untouched by their organization. Hospitals do a great deal of work for such people, but there is still a considerable field for medical treatment at the homes of many of them.

The paternal tendencies of present-day Governments, however, largely favour the introduction of

an insurance system. Although it is recognized in certain quarters that it is not always for the good of any part of a community that it should be spoon-fed, and that the independence and self-respect of the people are worthy of encouragement, and may be best maintained by allowing them to render such payment as is in their power for any benefits received, we are likely to see the initiation of the provision of medical attendance for wage-earners at the expense of the general taxpayer. There is a precedent for the adoption of such a system in the provision of educational facilities for people of the less well-to-do classes, and really for all classes. Even in our university curriculum the education which we have in Melbourne enjoyed is largely State-aided, though not entirely State-maintained. It is not a far call from a national educational system to a national health or medical attendance system, so in the future we may see a system of State-aided medical attendance to the less well off wage-earning classes, as educational advantages are given to the children of such classes in State schools, while the rest of the community will have their medical wants supplied by the private practitioner in much the same way as private and the large public schools provide educational facilities for those able to pay for them. Can we suggest any other or better method as a substitute for this national medical attendance system? Is it possible by any arrangements between medical men and patients to provide medical attention for the wage-earners, which shall be at once efficient and within their means? There is no doubt that an extension of the Friendly Societies system, the advantages of which should be definitely restricted to certain classes of the population, and in which the remuneration is more in keeping with the value of the services rendered than at present would be advantageous both to medical men and to the public. We might even imitate the action of the profession in New South Wales and have a Medical Benefit Society of our own, under the control of the British Medical Association, in which any member of the profession willing to act might be a medical officer of the Society and might be chosen by patients in his district as their medical attendant. There is another method of providing medical attendance in the nature of an insurance system which appears to be worthy of consideration. In Denmark,<sup>2</sup> it is the custom to provide treatment for families at a fixed annual fee, varying according to the income of the family. In general, the fee charged is about 1½% of the entire income, or about 10% of the house rent. The practice of charging an annual fee for medical attendance on families is, I know, regarded with disfavour by many medical men in Victoria; but if the rate of remuneration varied according to the income of the patients and the nature of the services to be rendered was clearly defined, I think that considerable good might arise by the adoption of such a scheme. The conditions for attendance could be determined by the Council or members of the State Branch of the Association, and, if adopted, such a scheme might be a means of providing for

<sup>1</sup> *British Medical Journal*, March 4, 1911, Supp., page 84.

<sup>2</sup> *Lancet*, June 3, 1905.

any of the medical wants of the community, even for specialists' services and operations.

The trouble in any system is to provide treatment which shall be at all times economical and efficient. Granting that much of the present lodge practice consists of attention to trivial diseases, still there is a certain proportion of cases which, though apparently trifling, represent the early stages of conditions that may become serious if not early diagnosed and treated. It is the diagnosis of such cases that takes time, and time to lodge practitioners, as elsewhere, represents money. Patients cannot expect to get what they are not prepared to pay a reasonable sum for, and there is little doubt that present remuneration for medical services under lodge conditions is not adequate, and must be increased.

#### Hospital Accommodation.

There is, as we all know, a growing tendency for hospital accommodation to be availed of by all classes of the community, and the advantages of such hospital treatment are beyond question. In the future extension of intermediate hospitals, which have already been of great service in Melbourne, there is a possibility of much greater efficiency in scientific medical work. Larger and more thoroughly equipped private hospitals, providing as much in the way of laboratory and other assistance as is given in general hospitals, are, I believe, likely to be seen in the future. One cannot help being impressed by the value of the work done in such an institution as the Mayo Clinic, and we may look forward with pleasurable anticipation to the establishment of a similar institution in some of our large cities, as being a valuable place of cure and research. Whatever is done in the way of further provision of medical attendance, whether in hospitals or any form of contract practice, should certainly include efficient treatment of all cases. This means the exact diagnosis of early conditions of disease, and for this bacteriological and clinical laboratories, and all the refinements of precise diagnosis, are required. It has often been pointed out that, whereas usually more importance is attached to the in-patient wards of a hospital than to the out-patient department, the reverse should obtain if the best results are to be got in treatment. This is especially so in medical cases, where disease presents itself in its earliest and often less recognizable forms in the out-patient rooms. It has even been suggested that promotions of honorary medical officers in hospitals should be from in-patient to out-patient departments. This may not commend itself to some of the senior men, but there is a great deal to be said in favour of the principle which underlies the proposal.

#### Preventive Medicine.

We all know the value of early recognition of infectious epidemic diseases, and the investigation of these diseases calls for the services of men specially trained in their recognition, usually by exact bacteriological and other methods. Our present Health Officer system has been frequently enough condemned, and it is to be hoped that after the war specialist officers of health will become the usual in-

stead of the rare variety. The establishment of laboratory facilities is a necessary corollary of such specialist officers, and the laboratory accommodation of general hospitals might very well be availed of for such purposes. Such laboratories might be under the direction either of a trained clinical pathologist attached to the hospital or of the Medical Officer of Health, and the co-operation of those laboratories with a central institution (in Victoria the University pathological and bacteriological departments) would aid materially in recognizing and stamping out epidemic diseases as well as in affording exact diagnostic facilities in other diseases.

The recognition by the public of the desirability of such measures in the prevention and limitation of disease implies that the public must be well aware of the necessity for them, and this means the education of the public by the profession, and especially by sanitarians, in the principles of health and the precautions to be taken in preventing disease. Such work has been done in America by the Harvard Medical School, which some years ago undertook to organize courses of free public lectures, which were delivered by well-known medical men on Saturday evenings and Sunday afternoons. If suitable lecturers could be obtained, and this might be done in large centres without much trouble, it might be possible under the auspices of such a body as the Australian Health Society to assist the cause of public health materially. The Australian Health Society has already rendered valuable services in this respect, and its efforts deserve a more general recognition and encouragement from members of the profession.

#### Medical Education.

To refer to matters that are perhaps more immediately connected with our profession, the question of medical education is one of much importance. To those who examine the papers of fifth-year medical students it would seem that the standard of general education for them is none too high. It may not be possible for our State University to follow the example of some others overseas, which compel the intending medico to obtain an Arts degree first; but any lowering of the standard for entrance examinations should be discountenanced. A certain amount of culture should be a necessary preliminary to a medical education. I do not know that our candidates for medical degrees are any worse than those from other schools, but I think that a little "tightening up" of entrance examinations might be advantageous. I hope too that eventually more insistence will be placed on the acquirement of modern languages than has hitherto been the case. There seems to be not much chance of any of the present living languages and certainly not of one of the dead languages becoming the common tongue of scientific people, why not a new language, such as Esperanto, or some modification of it. The requirement of a matriculation pass in Esperanto might be a valuable aid in this direction, and the additional advantage would be gained that, if similar action were taken elsewhere, the bond of a common language might conduce to better understanding between

peoples and in some degree help to prevent such a catastrophe as the present war.

The place of the set lecture in such subjects as medicine or surgery, away from the bedside of the patient or the lecture-room attached to it, has been the subject of frequent discussion. With the multiplication of good text-books the necessity for such formal lectures is comparatively small, and if it were not for the requirements of the General Council of Medical Education and Registration in England, one would hope that the number of them would still further diminish. In an address delivered by Sir W. Osler,<sup>3</sup> he says, "When I returned to Montreal in September, 1874, the Professor of the Institutes of Medicine had had to retire on account of heart disease, and, instead of getting, as I had hoped, a position as his demonstrator, the faculty appointed me lecturer, with the ghastly task of delivering four systematic lectures a week for the winter session, from which period dates my ingrained hostility to this type of teaching." Some systematic lectures are no doubt necessary nowadays, but so much has to be done by the student in the practical acquaintance with ward and clinical laboratory work that any time saved from unnecessary lectures in this direction would be a welcome relief to him. The American plan of "Recitations," where the Socratic plan of interrogation by teacher of students regarding cases just seen at the bedside is followed, commands itself to some as an excellent method of instruction.

When the student has acquired his degree, is he always fit to undertake the responsibility of general practice, sometimes in a remote part of the country, with no medical assistance close at hand? That he is not always so, even under the most favourable conditions, is recognized by the best students, whose desire is to gain the further experience which is afforded them in the position of resident medical officer at a hospital. The weaker students, those whose position in the class lists is low, are often unable to gain one of these much-sought-for positions, and consequently start practice with an additional disadvantage. Would it not be possible to make an extra year to be spent at a fair salary as resident officer to a hospital compulsory for all students, perhaps giving them a license to practice after they have passed their examinations at the end of the fifth year, and a university degree after a further year in hospital? In a country which shall be nameless, but in which the organization of medicine, as of certain other less innocent sciences, has reached a high stage of perfection, this additional year has to be completed before either a license to practice or a degree can be obtained. After the student has finished the sixth year, he nowadays, often proceeds to other branches of study before settling down to practice. He either begins to study a specialty, or does some scientific university or research work. Too little of the latter has hitherto been done here, and it is to be hoped that facilities for research will be provided when times are more propitious. That there is an almost boundless field for research is evident to those who come in contact

with the problems daily presented in clinical medicine, and even although we are a comparatively small community, and far removed from the larger centres of scientific thought, it is but right that we should take our part in elucidating problems of medical interest. Valuable work has already been done here in such matters as miners' phthisis, the healing of nerve injuries, cerebro-spinal meningitis, and the amount of success obtained in such instances is an earnest of the possibilities that lie before us. Thus, the question as to the degree to which hard manual labour is responsible for arterial and cardiac lesions, apart from infection and trauma, is one which requires elucidation. It would be interesting to know whether the "go easy" methods of modern times have any physiological basis which would recommend their general adoption.

A scheme deserving of consideration has been brought forward by the Dean of the Medical Faculty of the University of Otago, New Zealand. This scheme, *inter alia*, proposes the foundation of Dominion Medical Scholarships, to be awarded to students entering on their fifth year of medical study. The scholarship consists of free board and lodging in a hospital during the final year of study, and the payment of all class and university fees. The successful scholar, after graduating, is to serve in some one of the Dominion hospitals at a yearly salary of £150 and £200 respectively for two years. He is then to be free if he chooses to leave the department, but in cases of suitable merit, and where the scholar wishes to continue in the public service, the department may grant a travelling scholarship, to enable him to proceed abroad to gain experience in hospitals, etc. On his return, the scholar has to undertake to serve for two years as hospital superintendent, or assistant superintendent, or to fill some other departmental position, such as mental hospital superintendent, medical officer of health, medical inspector of schools, or Army Medical Service officer. It may be mentioned that such positions can be obtained at once by scholars at the end of their second year's hospital service, but the opportunities of acquiring experience in other countries should be a great inducement for holders of these scholarships to choose in many cases the overseas course of training. There is no doubt that in Australia we require generally a broader outlook, and any provision for education by travel and experience in older lands is deserving of encouragement.

Another department of medicine in which there has so far been very little done here is that of post-graduate work. At times excellent post-graduate classes have been held in our city, but of systematic organization for post-graduate instruction there has been none. After the present unfavourable conditions have passed away, an attempt should certainly be made to institute some such instruction. We might begin by having a series of demonstrations and clinical lectures lasting a week or more at the University and hospitals. Where so many men are fully occupied with their ordinary work, not much can be expected of any one man, but the co-operation of a number of University and hospital teachers should give a very good course, that might be very

<sup>3</sup> *British Medical Journal*, January 3 1914, p. 10.



advantageous, especially to practitioners living some distance from large centres. Might I suggest as a suitable time for such a course the last week in October; at this time, even without a post-graduate course, there seems to be some magnetic influence, which attracts medical men to the city, and advantage might be taken of this to ensure a larger attendance than could be obtained at any other time of the year.

#### The Work of the Association.

Lastly, as regards our own Association, what is the outlook? There is no doubt as to our power if we are properly organized and directed; we must first have the cordial co-operation of members of the Branch in all the departments of our work. The attempts made some time ago to organize the Branch have had very satisfactory results. Our members comprise a large proportion of the eligible practitioners in Victoria, and it is gratifying to notice the ready response given by young graduates to the invitation to become members of the Association. Unfortunately, we will have always in our midst some unethical members of the profession, whom we cannot include as members. Probably some of them would not have become ineligible if a satisfactory solution of the contract practice problem could have been found; however, this question is necessarily in abeyance till the termination of the war.

Personally, I have had a certain amount of regret that a section of the profession which has the same education and qualifications as ourselves, and which is separated from the rest of us by the fact that its practice is based on an exclusive dogma should be ineligible for membership of the Branch. However, we have to recognize the justice of the principle of exclusion for such reasons, and it is to be hoped that eventually further enlightenment may cause the abandonment of adhesion to any exclusive dogma as a fundamental basis of practice.

It is a matter of regret that the Branch is not better housed. The premises which we occupy are quite inadequate for the present requirements of members and of library extension, and the trouble will become greater as time goes on. If our President's scheme of providing for our needs in a centrally-situated building were capable of speedy accomplishment, a good beginning could be made and the intimate association of a medical school of research work, and the activities of the Branch of the British Medical Association would be of great and lasting benefit to medical education in its widest sense, and to our progress as a Branch. If this scheme is not possible at some early time, might it not be within reasonable expectation that, in some central and accessible situation, more room might be found for the Branch. In three sister States—New South Wales, Queensland and South Australia—convenient premises have been erected, and have proved not only of great service to the local Branch, but have been successful from the financial point of view. Last year, in Queensland, after providing for the expenses of the Branch and for interest on capital, a sum of £200 was available for reducing the debt on the building. I hope that some movement in this direc-

tion will be possible when the times are more nearly normal. Perhaps there may be a prospect of the Branch receiving something from the organization fund which might provide the nucleus of the necessary monetary requirements.

I hope too that after if not before our present national troubles are over, there may be a further movement towards the federation of the Branches in Australia. A Federal Council has been formed, to consider matters of Federal importance, but this body has been rather quiescent recently. There are many questions that are particularly adapted for the consideration of this Council, such, for example, as uniform principles of exclusion and readmission of members, the relationship of Branches to the Home Association, etc. In our Branch Council the necessity of decision on many of these matters is often felt, and more frequent meetings of the Federal Council are highly desirable. It may, I think, be said with confidence that the Federal view is one that is stressed by *The Medical Journal of Australia*, and we may congratulate ourselves on the success of this Federal venture. Both from the scientific and the medico-political point of view, as well as in other ways, the journal is doing good work, and reflects the gifts and energy of its Editor. It is to be hoped that he will have the co-operation of all members in his endeavours to ensure the continued success of the journal.

But it is time to bring these somewhat discursive remarks to a close. Opinions here are at times very much divided, even as to the larger issues which affect Australia and the Empire. As members of the British Medical Association we cannot but recognize the prestige and advantages which we enjoy from our connexion with the parent Association. In a similar way our position as citizens of Australia is indissolubly bound up with the great Empire to which we owe allegiance. As medical men we recognize our duty to humanity, and certainly not less also to the country in which we owe our many advantages, and which seems to us to be characterized by the possession of humane and enlightened ideals. We are all, I hope, believers in the destiny of Australia, but if our country is to have a great future, its people must exhibit untiring energy, much organization and a great deal more self-sacrifice than it has yet shown. I hope it may be said of us that we have tried, as medical men and British citizens, to live up to the standard set by the people of the Mother Country, and that we are as ready to share in the sacrifices and trials of the Empire as in the benefits which we enjoy under British rule.

#### SOME ASPECTS OF THE ÆTIOLOGY AND EPIDEMIOLOGY OF CEREBRO-SPINAL FEVER.<sup>1</sup>

By J. BURTON CLELAND, M.D., Ch.M. (Syd.),  
Principal Microbiologist, Department of Public Health, Sydney.

(Continued from page 499.)

#### The Detection of the "Carrier."

The detection of the "carrier" himself is a matter of considerable difficulty unless ample time and culture material are at the disposal of the bac-

teriologist. Considering the heavy incidence of the "carrier" stage on the general population, I do not think one is really justified in isolating "carriers" unless the organism has, with a reasonable degree of accuracy, been identified as a meningococcus. Isolation merely because a few Gram-negative diplococci are found in the throat without further tests being applied, seems to me unwarranted. If a proved meningococcus, however, has been obtained from a throat, and is present in considerable numbers, I think everyone must agree that such a person should be isolated and treated until free from infection. Especially does this apply to convalescents from the disease.

I doubt whether a person harbouring very few meningococci is really a danger to others unless their numbers increase markedly from time to time. Unfortunately we have no means of ascertaining whether a person who to-day obviously has a few, but very few, meningococci in this throat, may not to-morrow show them abundantly; so that here again isolation is justified until the throat is clear.

We have found it unnecessary to use a "guarded" swab for obtaining cultures from the naso-pharynx. An ordinary diphtheria swab, slightly bent, can with care be easily applied to this region, and withdrawn without contamination. It is sometimes an advantage to place the supposed carrier in the prone position.

We have also found that the more rigorous the tests applied to Gram-negative organisms isolated, the less is the percentage of positive results.

#### The Conditions Favouring Transmission from a "Carrier" to Another Case.

The meningococcus is excessively susceptible to drying; in fact some experiments of ours (which require confirmation) seem to show that it is no longer viable as soon as the material in which it is suspended becomes dry. This liability of the organism to death from drying is exceedingly important in considering the control of the disease.

Taking as a reservoir for the organisms the naso-pharynx of a "carrier" or of a convalescent from the disease, how can the meningococci in a viable state reach the naso-pharynx of other persons? Since they resist drying so imperfectly, obviously the dry fomites and surroundings of "carriers," and cases are non-infective. It seems clear, except in cases where perhaps a large blob of infective mucus is deposited on some material by the "carrier," and gains access through the mouth or nose to the naso-pharynx of another person before it becomes dry, that such surroundings of "carriers" and cases are non-infective. It seems clear, present knowledge, in spreading the disease. Obviously the means of spread must be something more direct. Mouth kissing is, for instance, a very suggestive source. Apart from this, infection by moist droplets of infective mucus must be considered. Under ordinary conditions of speaking and behaviour it would appear that few and very small particles of mucus are ejected by a speaker and suspended in the atmosphere. From the small size of these particles drying must be rapid and almost

instantaneous. For infection to occur from such droplets they would presumably have to reach a moist surface on the recipient almost as soon as they were expelled. A "carrier" under these circumstances could not infect a room with suspended particles which would remain moist sufficiently long to enable another individual entering the room five minutes later to be infected by the droplets. A "carrier" coughing openly or sneezing may, however, expel much larger and much more numerous droplets of mucus. Whilst the large particles would soon settle, smaller ones would remain suspended for some time. In these cases infection of persons in proximity to the "carrier" might occur at the expiration of the fit of coughing or sneezing. Persons in specially close contact with each other, for instance sleeping close together in the same blanket, might become infected owing to their proximity to each other in a confined space removed from currents of air, even apart from such coughing or sneezing. I would summarize this aspect of the danger of "carriers" to others as follows:—

1. Persons harbouring the meningococci in their naso-pharynx are not dangerous to others as long as these organisms are not expelled from their situation.

2. During ordinary conversation and behaviour, apart from spluttering individuals, the danger of such "carriers" to their entourage is probably very small owing to the few particles of infective mucus expelled and to the rapid drying of these.

3. Under these circumstances the danger is still more minimized when there is a very free circulation of air, especially of dry air, around the individuals concerned, as in well ventilated rooms, and more especially in the open air. The danger is increased on the other hand when the individuals are very closely associated in a warm, moist, unventilated atmosphere, still more so when lying close together and covered by the same blanket.

4. Coughing and sneezing and spluttering methods of speech favour the means of transmission from the "carrier." Danger to others is further increased when he is subject to naso-pharyngeal catarrh, or to attacks of sneezing due to the irritation of dust, insect powders, and other fine irritating particles productive of attacks of so-called "hay-fever." The increased incidence of the disease in the early spring or at the end of the winter may perhaps be partly attributed to the increase of catarrh at this time, leading to greater expulsion of particles of mucus, and these being of a larger size.

I am of opinion as a result of the above summary that the "carrier" is not dangerous to others:—

1. If he does not kiss other people;
2. If he is not suffering from naso-pharyngeal catarrh, or from attacks of sneezing;
3. Does not splutter in speaking, or address other persons face to face; and
4. Does not go into closer personal contact with the faces of other individuals than say three feet.

I consider it likely that uninfected individuals are more likely to become infected

1. If they listen open-mouthed to remarks of a "carrier" when they are close to such "carrier."
2. When they and the "carrier" are speaking face to face at the same time.
3. When their noses are unusually patent so that suspended particles inhaled pass the barrier of bristles and mucus in the anterior nares, and
4. When they are suffering themselves from congested conditions of the throat and nose, favouring multiplication of the organism when it reaches these sites.

I consider that uninfected persons can lessen the risk of becoming infected when in the neighbourhood of "carriers."

1. By breathing through the nose as much as possible, and keeping the mouth closed.
2. By keeping as far apart from other persons as possible during conversation.
3. By keeping their faces averted as much as possible from persons speaking to them, or coughing or sneezing in their presence, and
4. By blowing their noses after being in the neighbourhood of suspected "carriers," so as to dislodge from the nostrils infective particles that may have lodged in the anterior nares.

#### Is Cerebro-spinal Fever Primarily a Septicæmia?

Statements are made from time to time that cerebro-spinal fever is primarily a septicæmia, followed by localization of the organisms in the meninges accompanied by cessation of the septicæmic period. This view is based on being able to grow the organism in some cases early in the disease from the blood, and also on being able to cultivate it from the urine. The use of the word septicæmia seems to me wrong. In a true septicæmia the organisms not only exist in the blood, but multiply appreciably therein. Anthrax is a true septicæmia, and the bacilli may be found in numbers in the blood. In septicæmic plague I have found them in smears where they were at least as numerous as the leucocytes. In puerperal septicæmia chains of streptococci may be found in the blood. In these cases the blood is forming a true culture medium for the organisms. In cerebro-spinal fever, however, in pneumonia, and in typhoid fever, I look upon the occurrence of the specific organisms in the blood as merely representing the washing or leaching into the circulation of a certain number of the organisms that crowd the affected area. When in any part of the body to which blood and lymph have access there is an enormous accumulation of minute infective organisms, it stands to reason that a certain number of these must gain entrance to the circulation, and be distributed to various parts by the blood. I do not consider such leaching-out processes constitute a true septicæmia, and I do not think this term is applicable to the state of affairs found in cerebro-spinal fever. I consider their presence in this disease is merely an indication that somewhere in the naso-pharynx, or in some other part of the body, there is a considerable collection of the responsible organism, and that from this focus a certain number of the meningococci have entered

the circulation by which they may be distributed to other parts.

Since reading this paper, General Fetherston has kindly forwarded me the following information in reference to cerebro-spinal fever amongst soldiers in Australia, compiled by Captain W. J. Trehwelle:

#### Reports of Suspicious Cases and the Earliest Definite Cases Recorded and Treated at No. 5 Australian General Hospital.

The list shows that the first case of meningitis was reported on June 4, and the second recorded case on June 12, 1915. Thereafter cases occurred on the following dates: July 1, 6, 13, 15, 29 (2 cases), 30. Prior to this, on May 17 and 25, three cases of measles were admitted, and all died within three days of admission. On May 27 a doubtful case of cerebro-spinal meningitis was admitted, and died on the same day, and on June 1, 3, 14, 15, 22, 28 and July 14, 21, 22, and 30 cases diagnosed as influenza were admitted and ultimately died.

With the meagre information in our possession it is impossible to state when the first definite case of cerebro-spinal meningitis was admitted to No. 5 Australian General Hospital, and whether the cases of measles and influenza which were so fatal at this period, may not, some of them at least, have been cerebro-spinal meningitis unrecognized as such. A perusal of the list will also show that the first recorded cases of cerebro-spinal meningitis appear to have come firstly from Broadmeadows, and later from Flemington.

*The Greatest Intensity of the Epidemic.*—The number of cases diagnosed as cerebro-spinal meningitis reported between July 29 and August 29, 1915, was 49, of which 41 were transferred to Alfred Hospital. Seven died at No. 5 Australian General Hospital, and one was discharged as cured.

The number of suspicious cases diagnosed as influenza was six, of which four were transferred to the Alfred Hospital, and two died in this hospital.

Three other deaths were recorded during this period, of which one was not diagnosed, one was considered as due to heart failure, but was probably due to cerebro-spinal meningitis, and one was considered as due to pneumonia, death resulting within twenty-four hours. This may also have been cerebro-spinal meningitis.

This period evidently covers the time when the epidemic was at its greatest intensity, and there is no evidence forthcoming at No. 5 Australian General Hospital to show any definite cause for it outside of the conditions prevailing in camp life during the early stages of organization.

*Question of the Introduction of the Disease.*—The first batch of returned soldiers arrived from Egypt on March 11, 1915. The same boat returned with the first batch of wounded soldiers on July 24, 1915. There is no record here of any returned soldier being admitted to No. 5 A.G.H. with cerebro-spinal meningitis at this period, and we are unaware of any soldiers having developed the disease on transport at this time, and therefore, with the information at our disposal, we are unable to trace any reasonable connexion between returned soldiers and the cerebro-spinal meningitis epidemic, nor can we trace the path by which the epidemic could have been introduced from Egypt.

General Fetherston informs me that the camps mentioned are both at or near Melbourne, and that the report refers to cases returned to Victoria.

#### References.

- <sup>1</sup> Fairley and Stewart—"Cerebro-spinal Fever," Commonwealth of Australia, Quarantine Service Publication, No. 9, p. 10.
- <sup>2</sup> Champtaloup and Bowle—*The Medical Journal of Australia*, August 7, 1915, p. 119.
- <sup>3</sup> Chalmers and O'Farrell—*Journal of Tropical Medicine and Hygiene*, May 1, 1916.



## The Medical Journal of Australia.

SATURDAY, DECEMBER 16, 1916.

### Medical Science in Australia.

Each year the chosen leader of the profession in the several States of Australia reviews a chapter in the history of the medical profession as it has been revealed to him during his year of office as President of one of the six Branches of the British Medical Association in the Commonwealth. These addresses are always prepared with care and skill, and, thanks to the diversity of treatment of the various subjects, to the erudition of the speakers and to the brief intervals of recurrence, members of the medical profession are enabled to obtain a comprehensive grasp of the position of the medical practice and of the relations obtaining between the profession and the public. Few addresses of this category have contained sounder philosophy or more cogent argument than that which it is our privilege to publish in the present issue. Dr. A. V. M. Anderson has placed the Victorian Branch under a debt of gratitude to him for the manner in which he discharged his onerous duties as President during a year of trials, dismays and darkness. His masterly survey of the year's work adds to this debt.

The medical profession exists for the security of the public. Its primary function is to supply the community with means of avoiding disease and of grappling with it when present. The degree of success with which the endeavours of its members are attended depends as much on the penetration of the scientific physiologist and pathologist as on the perspicuity of the clinician and therapist. The majority of the problems to which the British Medical Association has to address itself is the direct result of a want of understanding of the structure and functions of the human body and of the diseases which attack it. If it were possible for medical practitioners to be equipped with a full knowledge of the body in health and disease, the moot problems in medico-politics would disappear and the cry for a professional form of trade unionism would vanish

with it. Unfortunately, medicine is still an art more than a science, and we fear that its practice is frequently a trade. The medical profession has itself to blame in many instances when the public haggles over terms or threatens to introduce a system of control of practice by organizations or by the community itself. In other countries the necessity for the introduction of national insurance has arisen as an indirect result of inadequate safeguarding of the public health. Inefficient and insufficient medical care leads to the demand for a system of State control. Friendly societies would find it economical to pay their medical officers liberally if the knowledge gained were employed in the practice of preventive and curative medicine. The acquisition of knowledge and its application to practice is the keynote to a better relationship between the medical profession and the public.

There is nothing local in the fundamental principles which should govern our practice in preventing disease and in coping with it. Local conditions vary within narrow limits in connexion with the form of prevalent disease and in the legislative and social measures taken to combat it. The problems in medical politics vary in different parts of the Commonwealth, chiefly because reform is driven along at an uneven pace in different places. Essentially the medical profession must utilize the same means to attain a common end, no matter where this endeavour is made. Dr. Anderson has therefore called attention to the advisability of regarding our problems in a Federal aspect. Co-ordination between the Branches of the British Medical Association, uniformity in standards of medical ethics and medical politics and unification of the public medical services are essentials in the best interests of both the community and the medical profession.

### THE RECRUITING CAMPAIGN.

The year of grace, 1916, is drawing to a close. Time and tide have waited for no man. Inexorable, ruthless and destructive, the war has claimed its sacrifices, and still the end is not yet. Another year will dawn, and in the morning men will go out to grip the enemy and to labour toward a goal. Happenings, perhaps more momentous than any of us

can presage, are contributing toward the destiny of our nation, of our great Empire, the Empire on which the sun never sets. France has long ago committed herself to *Liberté ou La Mort*; Russia must send as many as she can arm and feed; Britain is bracing herself for a supreme effort. She looks to her fledglings, her emancipated children across the seas for men and munitions and food. Under the new order of things in the Old Country we may expect a more active policy, a more energetic offensive and a greater demand for help from the Commonwealth and the Dominions. It may be that the people, stimulated by these stirring events and chastened by a sense of shame, will respond to the renewed call for voluntary recruits to take their stand with the "artillery-men, little powder-devilkins, plying their hell-trade through the not ambrosial night," as Carlyle described a far less ferocious struggle. We are concerned with the other aspects of our Empire's stress. To some extent the demand for officers in the Australian Army Medical Corps must depend on the activity in the recruiting of combatant members of the Australian Imperial Force. But even though the immediate demand for men may be less urgent than it has been and than it certainly will be within a month or two, the duty of every member of the medical profession is clear and sharp. Notwithstanding the change in circumstances since the Director-General of Medical Services issued his memorandum, calling on all medical men under the age of 60 years to apply for commissions in the Australian Army Medical Corps Reserve, the need for men continues and a slackening of our efforts to provide the troops with the best medical care available could only be interpreted as an indication of a want of appreciation of the danger in which Britain and her Allies still stand. The organized effort of the men in a small but active section of the New South Wales Branch of the British Medical Association has spread, and enthusiasm has been awakened. Fortunately, this movement is infectious, and the spread will continue until the whole Commonwealth is embraced. The work of the recruiting committees will be facilitated if members will regard the situation widely and largely. The military authorities require an unknown number of men for a variety of tasks in divers places. If every medical man whose

services could be utilized in some capacity would join the Reserve, those in authority would be able to secure an adequate performance of each duty with the least amount of inconvenience to the general public, and would be in a position to suggest to the most suitable men for service abroad that they should extend their willingness to serve their country by agreeing to a transference to the Australian Imperial Forces. We would emphasize the fact that no man in the Reserve can be sent to the front unless he agrees to go of his own free will.

#### THE SCHOOL CLINIC IN SYDNEY.

During the last days of November the Minister of Education of New South Wales announced that a large number of medical officers had been appointed to undertake the treatment of school children found defective at the inspection, and not treated for these defects. There are some things connected with these appointments which we do not understand. One of these puzzling things is contained in the estimates which have been placed before the House. In the table dealing with the officers of the Medical Branch of the Department of Education, the total number of officers provided for is the same as that provided for last year. Notwithstanding this fact, the total amount asked for in respect of salaries of medical officers, dentists, typists, clerks, nurses and cleaner is £4,813 more than in the previous year. The tables are arranged as follows: The two columns on the left-hand side of the page indicate the number of officers in the previous year and the number provided for for the ensuing year. Then comes a description of the position and the class under which the appointments are made; while the last two columns contain the aggregate salaries of each group of officers. The entries given below are those of medical officers.

Number of Persons. 1915-16, 1916-17.		Division of Service.	Salaries and Contingencies. Amt. ap- propriated for year ending June 30, 1916.		Amt. ap- propriated for year ending June 30, 1917.	
			£	£	£	£
1	1	Principal Medical Officer	Professional	800	800	
7	5	Male Medical Officers at £500	Professional	3,500	2,500	
6	6	Female Medical Officers at £400	Professional	2,400	2,400	
8	10	Male Medical Officers at £600	Professional	2,400	6,000	
1	1	Ear, Throat and Nose Surgeon	Unclassified	150	300	
1	1	Ophthalmic Surgeon	Unclassified	125	250	
1	1	Physician and Anæsthetist	Unclassified	125	250	

The arithmetic of the officers of the Education Department is original. Eight medical officers at £600 a year each appear to cost the Department only half

as much as they would cost an ordinary employer. It is, of course, just possible that the figure "8" should read "4," in which case the estimates provide for six extra officers in this group. It is significant that the salaries of the ear, throat and nose surgeon, the ophthalmic surgeon and the physician and anaesthetist are doubled. It has been suggested that the compositor has been wicked in the setting up of the first two columns, and that the number of part-time officers has been doubled. It may be so; but would it not be better for the members of the House and the public to know these things? If our surmises are correct, there would be six additional medical officers at £600 each, and three part-time men at £150, £125 and £125 each respectively, and there would be two medical officers less at £500 a year each, or a net gain of seven medical officers.

#### WILLIAM GILBERT.

Men have been ever ready to keep green the memories of those who have served them by discovery and invention. When many men in their own age make use of the increased knowledge and when succeeding generations reap the benefit of what has been learned, the character and attainments of the inventor are objects of interest. Men wish to know where the inventor was born, what adventures befell him, whom he loved and how he had his share of of the joys, sufferings and sorrows that encompass the lot of life. Between three and four hundred years ago William Gilbert followed the practice of a physician in London with great success. Born in Colchester, he had been educated at Cambridge, where he became a Doctor of Medicine in 1569. After graduation Gilbert followed the custom of his time by travelling for five years on the continent of Europe, where he made the acquaintance of Giordano Bruno and Sarpi. He settled in London in 1573, was elected a Fellow of the Royal College of Physicians, of which he became censor, treasurer and president in 1599. He died of the plague in 1603. As personal physician to the Queen, he attended Queen Elizabeth in her last illness.

The fame of Gilbert is dependent on a single work written in Latin, and entitled "On the Magnet and Magnetic Bodies and on the Earth Regarded as a Great Magnet, a New Physiology Demonstrated by Many Arguments and Experiments." The word physiology was used in the sixteenth century with much the same signification as is attached at the present day to the term "natural philosophy." It was not specially applied to the physics of the living organism until some time after the death of Gilbert. The *Physiologia* gives an account of the observations, experiments and conclusions made during eighteen years of patient and industrious research. The experiments form the bases of the sciences of magnetism and electricity, as they are now taught and studied, while the conclusions drawn from the facts and arguments became immediately of value to mariners, and have since become the foundation of the art of navigation. Gilbert's discoveries, which were inferred by induction from experiments, are the first

results gained in England by the methods now adopted for scientific research.

In magnetism William Gilbert observed the use of iron caps, called by him armatures, in increasing the strength of loadstones. He found that a bar of iron heated red hot, placed in the north-south direction and struck with a heavy hammer becomes a magnet. From this and other observations he proceeded to formulate the theory that the earth is a great magnet. Consequently he made a "dip circle" to measure the dip of the magnetic needle at various places on the earth's surface. He compared the results with those obtained on a spherical magnet, an orb of virtue as he quaintly calls it. He hoped with this instrument and the knowledge of the position of the needle in relation to a spherical magnet to measure latitude in the absence of sun, moon and stars. He studied the declination from the true meridian of the compass, and sought to explain this variation as due to the presence of the continental masses of the land. Well does Galileo say of these discoveries, "I extremely praise, admire and envy this author for that a conception so stupendous should come to his mind. I think him, moreover, worthy of extraordinary applause for the many new and true observations that he has made."

Gilbert's contribution to the foundation of the study of electricity occupies the second chapter of his book, and is contained in fourteen pages. Few pages are richer in the record of new and accurate observations. Gilbert surpasses in powers of lucid condensation his illustrious and younger contemporary, William Harvey, who gave to the world the whole of his important observations on the circulation of the blood in fifty-two pages of printed matter, and by no means large pages at that. The word electricity is used by Gilbert, and to him we are indebted for its selection. Static electricity has hardly progressed, except in details, since this master of the methods of investigation gave over its study. To him we owe the classes of electrics and non-electrics, the use of the electroscope, the electrification of bodies, the attraction of variously electrified bodies for all classes of substances, independent of the nature of the substance.

Gilbert made no contribution of fundamental importance to the study of medicine. His interests in this direction were restricted to assistance in the preparation of the London Pharmacopoeia, which was prepared under the supervision of the Royal College of Physicians. Gilbert served on numerous committees from 1589 until his death in this arduous task of freeing medicine in part from the load of superstition and charlatanism with which it has not yet ceased to be encumbered. Gilbert also gave attention to those diseases and distempers which appeared in the Royal Navy. He was appointed with three other physicians to have care of the health of the noblemen, gentlemen and others in that service when the fleet put to sea to guard Britain's shores from the Spanish Armada. With Whetstone and Hakluyt he stands one of the progenitors of the systematic study of naval medicine. With Bacon and Burghley, with Drake and Raleigh, he stands for the new birth of Britain's greatness.



## Abstracts from Current Medical Literature.

### SURGERY.

#### (215) Wounds of the Thoracic Duct.

Edward Harrison gives the history of a case of a wound of the thoracic duct, and discusses the treatment of this condition (*Brit. Journ. Surgery*, October, 1916). The patient was a pale, emaciated boy, aged 9 years. He had previously had some lymphatic glands removed from his neck. He returned to the Infirmary with an enormous mass of glands on the left side of the neck, extending from the jaw to the clavicle. A careful dissection was carried out, and after the mass had been removed a small quantity of material looking like pus was detected just above the clavicle. The fluid was seen issuing from the divided end of a vessel. It became quite clear that the vessel was the thoracic duct and that chyle was escaping from it. As it was certain that the boy would die of starvation if nothing were done, the author decided to implant the duct into a vein. The external jugular vein was chosen, and the implantation was carried out. The wound healed by first intention, and convalescence was uneventful. The patient wore a poroplastic splint to fix the neck from the tenth to the seventeenth day, so that any clot which might have formed would not be disturbed. He gained 7 lbs. in weight while in hospital. The author finds that there is scant reference to the accident of wounding of the thoracic duct in surgical text-books. According to Lotsch, a wound at a point close to the outlet of the duct is a rare complication of operations on the left side of the neck. At times chylothorax does not develop for some hours after the wounding. This is explained by the assumption that there is usually a slit in the wall, which is temporarily closed by blood clot. If the wound is untreated, the chyle escapes, sometimes in great quantities. The digestive organs work in vain, hunger and appalling thirst occur, and there is emaciation and progressive loss of strength. Fever may occur, but it is uncertain whether this is due to the absorption of nucleins and proteins or not. At times recovery ensues, and in these cases it is probable that an anastomosis takes place between the ducts on the two sides and a gradual dilation of the channels. The treatment may be by suture, which should be undertaken whenever it is possible. Failing direct suture, implantation into a vein should be attempted. This is stated to be the most physiological and rational form of treatment. Occlusion by ligature and pressure may be tried. The success of this plan depends on whether there are two terminal branches, or small collateral vessels communicating with the lymphatics of the right arm and right side of the

neck at their opening into the right subclavian vein. The author holds the opinion that the divided vessel should be traced up the neck and a second branch sought for. If this is found, the treatment by ligature is placed on a sound basis. Lastly, the accident may be treated by tamponage. Every other means must have been tried before resort should be had to tamponage. Cushing is of opinion that the tampon may act as a safety-valve, preventing too great pressure in the lymph channels. The author does not agree with this view. He prefers to attempt to regulate the rate of flow of chyle by dieting, and to allay the thirst by giving continuous infusions of saline fluid, to which a fine fatty emulsion might be added.

#### (216) Nails and Screws in Joint Surfaces.

Arthur T. Mann describes a series of experiments undertaken to determine the behaviour of nails and screws applied to joints, and to ascertain the nature of the changes which take place in response to their presence (*Surg., Gynec. and Obstet.*, November, 1916). He had under his care a boy, aged 7 years, who had been seen six weeks after an injury to the external condyle, which had been fractured and misplaced. Various means had been adopted to keep the fragment in position, but all had failed. The joint was opened and the condyle was nailed in place. Firm adhesions developed later, but were broken down. A serviceable arm was obtained; there was but moderate limitations at the extremes of motion. In an experimental series performed on dogs, varying degrees of care were taken of the knee-joints operated on. As a result of these experiments, the author has concluded that nails and screws are well tolerated in joints, both in human beings and in dogs. Very little reaction is caused by their presence. The nails remain firmly embedded in every case. When nails or screws projected beyond the articular surface, a distinct "upbuilding" occurred. An increase in the joint level seemed to be due to the growth of bone, and not to an increase in thickness of cartilage. New tissue growing across the head of a nail showed a reversion to the connective tissue type. Even when these foreign bodies remain uncovered, dogs recover the power of running about after a short time. The scratch or groove on the opposing surfaces became filled in as the projection of the nail or screw lessened by "upbuilding" of the condyle. He finds that it is advisable to swing a hinge joint freely at the time of the operation, in order to create a groove rendered necessary by a badly placed nail, rather than to allow the groove to form gradually at the cost of pain and disablement.

#### (217) Lipectomy and Umbilical Hernia.

The fact that an umbilical hernia, if allowed to remain unattended, is a dangerous condition is regarded by W. Lathrop as sufficient justification for

calling attention to this defect in anatomy (*Americ. Journ. Medicine*, August, 1916). After birth several changes take place in the closing of the umbilicus. According to Bickham, there is first a constriction and shrinking of the umbilical ring. As this ring closes, the umbilical vessels passing through it become divided. In the next place, clotting of the blood inside the vessels takes place. This leads to a proliferation of the connective tissue and a contraction of the muscle fibres of the vessels and a firm fibrous scar is thus formed at the umbilicus. It can thus be seen that a weakness of the scar may persist for some time, and this weakened tissue may be subjected to strain. As a result, a hernia may arise, either through the ring itself or through the abdominal wall in the vicinity of the ring. Prior to the employment of the overlapping method of closure of these herniae, recurrences were very common. The author deals with the operation of lipectomy in connexion with umbilical hernia. He points out that Kelly placed this operation on a firm basis in 1910 by removing large quantities of fat, in order to restore the contour of obese patients and to improve their comfort. He points out that excessive fat may interfere with the activities of life. If fat is uniformly distributed it can be reduced only by exercise, dieting and hygienic measures. When it is collected in one mass, as in a pendulous abdomen, sufficient amount can be removed to produce comfort and to obliterate the chafing and soreness. The author gives a description of the operation and details the histories of some cases. He has noted that in many cases a considerable reduction in weight follows the operation and that this reduction is a permanent one.

#### (218) Alternatives to the Operation of Colotomy.

John Stephen McArdle (*Practitioner*, June, 1916) says that in the whole history of surgery there is no operation so unsuccessful as colotomy. Although it may be life saving, the after effects are so distressing to the patient and so disagreeable to the friends that in many cases he thinks that it would be better for the patient to be dead than to survive a procedure so fearful in its consequences. The author suggests and practises anastomosis of bowel above and below the growth which causes the obstruction, and shows how, by the use of Hildebrand's button (a modification of Murphy's anastomosis between any portion of the bowel above the growth and the rectum may be successfully performed. The operations are described, and diagrams given, and the author concludes with the statement that, although he is fully aware that artificial anus is still the last hope of some operations, he can see no reason why surgeons should hesitate to give their patients a chance of fairly comfortable existence, instead of a prolongation of their misery.

## GYNÆCOLOGY AND OBSTETRICS.

## (219) Foetal and Placental Syphilis.

In opening a discussion on syphilis in obstetric work, E. D. Plass points out that there are other means besides the Wassermann reaction of arriving at a diagnosis of foetal disease (*Americ. Journ. Obstet.*, etc., October, 1916). The placenta, when affected by lues, differs materially from the normal organ. At times the *spirochaeta pallida* can be demonstrated either by Schaudinn's or by Levaditi's method, but a prolonged search for the organism is not justified in ordinary routine practice. Syphilitic placentae are usually much larger than normal ones, and may weigh from one-fourth to one-third of the weight of the foetus. The maternal surface has a greyish-pink greasy appearance, and the tissue is more friable than usual. On microscopical examination an obliterative endarteritis and endophlebitis are met with, and may be regarded as characteristic of syphilis. In well-marked cases the blood vessels may have disappeared entirely from the villi. Turning to the tissues of the foetus, the author calls attention to the fact that the demonstration of the spirochaete is absolute proof of the nature of the infection. The organisms are most numerous in the adrenals, lungs, and liver, and he therefore confines his search to these organs. He has investigated the organs of 75 babies dead of various causes for the presence of evidence of syphilis, both in the foetal organs and in the placenta. In addition, he has compared the results with those derived from a Wassermann test applied to the maternal serum. The result of this comparison leads him to the conclusion that the complement fixation test in the mother's serum is of less value in diagnosis than the direct examination of foetal organs or the placenta. Since negative results do not exclude a syphilitic infection, he advocates the employment of all diagnostic means in the cases of doubt.

## (220) The Correction of the Relaxed Abdominal Wall.

W. Wayne Babcock (*Americ. Journ. Obstet.*, October, 1916) recognizes three degrees of general relaxation of the abdominal wall. In the first, the anterior abdominal wall does not prolapse over the pubis when the patient is in the erect position. In the second, a fold of the anterior abdominal wall hangs over the pubis and Poupart's ligament, but does not approximate the thighs. In the third, the relaxed abdominal wall hangs some distance down over the thighs. The symptoms produced are a sense of weight, dragging and discomfort, those due to stasis and obstruction resulting from visceral displacement, and those referable to a diminished intra-abdominal tension. These include indigestion, headache, constipation and flatulence. The author deals with the operative treatment, as distinguished from palliative treatment. A resection of an elliptical area of skin may be employed to increase the tension upon the underlying structures. In the second

place, lipectomy may be carried out to reduce the weight of the anterior abdominal wall. The fascial and muscular planes may be reconstructed, and if necessary a reinforcement of the abdominal wall may be achieved by the implantation of some foreign substance, such as silver wire or kangaroo tendon. The reinforcement is carried out either by imbrication of one edge of the separated muscular aponeurotic layers over one another, or by splitting the abdominal wall into its component layers and imbricating each layer separately. Reinforcement with silver wire has the disadvantage that the material is not sufficiently flexible, and that its tensile strength is comparatively low. He has therefore introduced in the place of silver wire a fine silver chain, such as is employed by jewellers. He describes the various methods of applying this chain and securing it in the abdominal wall. The results obtained from its use have been satisfactory. In 40 patients operated on in hospital, from half to 14 pounds of fat and skin have been removed and the anterior abdominal wall reconstructed. Death occurred from heart failure a few days after operation in one case, and was ascribed to an increase of the intra-abdominal pressure. In another patient, secondary intestinal obstruction followed, which necessitated further operative interference. The obstruction was ascribed to the result of increased tension on old adhesions. In two other patients a transient glycosuria was noted after operation, which the author also regards as a result of increased intra-abdominal tension.

## (221) Pituitary Extract in Obstetrics.

L. G. McNelle records the case of rupture of the uterus following the use of pituitary extract, and attempts to define the limitations of employment of this substance in obstetrics (*Americ. Journ. Obstet.*, etc., September, 1916). In his case the head was well engaged, the os uteri was dilated to admit three fingers, and the uterine contractions were strong and regular. The presentation was left occipito-anterior. After a few hours the pains decreased in severity, and as progress was not made an injection of pituitary was given. Five minutes later the uterus was in tetanic contraction, and sudden pain and a feeling as if something had given way were complained of. Forceps were immediately applied, and a still-born female child, weighing 7½ lbs., was delivered without difficulty. Forty-five minutes after delivery the placenta was found free in the abdominal cavity. The abdomen was therefore opened and supra-vaginal hysterectomy was performed. The patient made a good recovery. The author has traced 16 reports of rupture of the uterus following the use of pituitary extract. Death resulted in 13 of the cases. A review of the literature and of his own experience leads him to formulate the following conditions as essential before the exhibition of pituitary extract is justified. There must be complete dilatation and effacement of the cervix;

the membranes must be ruptured; the presentation should be longitudinal and either vertex or breech; in cephalic presentations there should be no deflexion of the head; there should be no disproportion between presenting part and the pelvis; and, lastly, the presenting part should be completely engaged.

## (222) Sterility.

Polak (*Surg. Gynec. and Obstet.*, September, 1916) gives a review of 798 cases of sterility in women from his private practice. After enumerating the conditions which are essential for conception and the development of the ovary, he points out the necessity of always ascertaining the activity of the seminal discharge in the male and its freedom from infective bacteria before proceeding with the investigation and treatment of the female. He enumerates the main factors which prevent conception taking place; (1) Conditions of the cervix, which destroy or stop the spermatozoon from junctioning with the ovum. He asserts that even a weak acid secretion will destroy spermatozoa, and that thick muco-purulent secretion acts as an almost insurmountable barrier to the male element. (2) Conditions of the ovary which prevent healthy egg bearing; thickened tunica, chronic inflammatory changes, fatty degeneration, tumours, adhesions and senile atrophy, etc. (3) Conditions which interfere with the free transit of the ovum from the ovary to the uterus; congenital tortions, constrictions, angulations, diverticula and acquired lesions the result of inflammation, etc. (4) Conditions of the decidua of the uterus which are unfavourable to the implantation of the ovum and its continued growth; syphilis, circulatory derangements which produce hyperplastic and fungoid changes in the endometrium, fibroid tumours, sexual excesses, lacerations, subinvolutions with resulting endometrial hyperplasia. (5) The general health of the female. (6) Hypoplasia of genitalia, infantilism, congenital anomalies, displacements in which the cervix is removed from the seminal lake and chemico-physiological action of discharge of any part of the genital tract. He records and classifies his cases, and proceeds to indicate the mode of treatment adopted in each variety. He concludes:—(1) That many women applying for relief of sterility have no chance whatever of becoming pregnant, because the pathology of the condition renders conception impossible. (2) That the male is largely responsible for the bad results of treatment. (3) That there is a definite chemico-physiological factor in conception, at present unexplained, and its disturbance is a cause of sterility. (4) That operative procedures on the uterus, except amputation of the hypertrophied portion, have but a slight influence on the end-results in the treatment of sterility, and finally, that each case must be investigated individually, and both contracting parties carefully studied before any treatment is inaugurated.



## British Medical Association News.

### ANNUAL MEETING.

The Annual Meeting of the Victorian Branch, and simultaneously that of the Medical Society of Victoria, was held at the Medical Society's Hall, East Melbourne, on December 6, 1916, Dr. A. V. M. Anderson, the President, in the chair.

### Election of Office-Bearers.

The President announced the result of the election of office-bearers and of members of the Council and of the Committee for the ensuing year.

**President:** Professor R. J. A. Berry (unopposed).

**Vice-Presidents:** Drs. W. Ernest Jones and R. L. McAdam (unopposed).

**Honorary Treasurer:** Dr. C. H. Mollison (unopposed).

**Honorary Secretary:** Dr. J. W. Dunbar Hooper (unopposed).

**Honorary Librarians:** Drs. H. Douglas Stephens and Allen Robertson (unopposed).

**Members of the Council and of the Committee:** Drs. A. V. M. Anderson, L. J. Balfour, W. R. Boyd, B. Crellin, T. P. Dunhill, R. H. Fetherston, Konrad Hiller, Basil Kilvington, Alex. Lewers, A. Norman McArthur, R. R. Stawell, A. E. R. White, J. F. Wilkinson and A. Jeffreys Wood.

Drs. Hooper and Mollison acted as scrutineers.

Dr. Anderson then vacated the chair, and on calling upon Professor R. J. A. Berry to replace him said that they all knew him to be a very busy man. He therefore trusted that Council and the members of the Branch would extend their consideration to him during his year of office.

Professor Berry thanked the members for the high honour they had done him by electing him to the presidential chair. Owing to the nature of his professional duties, he would not be able to give such unremitting attention to the work as his predecessor had done, but he would do his best. He had been elected as a representative of a science, and he promised that he would bring before the members matters of a highly scientific and interesting character.

### Annual Report.

The Annual Report of the Council was presented.

**Annual Report for Year Ending December 6th, 1916.**

The Council of the Victorian Branch of the British Medical Association and the Committee of the Society present the Annual Report for the year 1916:—

### Election.

At the Annual Meeting held last December the following office-bearers and members of the Council and of the Committee were elected:—

**President,** Dr. A. V. M. Anderson; **Vice-Presidents,** Prof. R. J. A. Berry and Dr. R. L. McAdam; **Hon. Secretary,** Dr. L. S. Latham; **Hon. Treasurer,** Dr. C. H. Mollison; **Hon. Librarians,** Drs. Allen Robertson and H. Douglas Stephens; **Members of the Council and of the Committee,** Drs. L. J. Balfour, W. R. Boyd, B. Crellin, J. H. L. Cumpston, F. L. Davies, Konrad Hiller, Andrew Honman, A. L. Kenny, Alex. Lewers, Alan Newton, W. Ostermeyer, A. E. R. White, J. F. Wilkinson, and A. Jeffreys Wood.

At a subsequent meeting of the Council the following appointments were made:—**Hon. Assistant Secretary,** Dr. J. W. Dunbar Hooper; **Hon. Assistant Treasurer,** Dr. W. Ernest Jones. Later in the year Dr. Latham resigned his position on the Council on being accepted for military service abroad and Dr. Hooper was appointed **Hon. Secretary**, with Dr. Davies as **Hon. Assistant Secretary**, the vacancy on the Council being filled by the co-option of Dr. R. H. Fetherston. Dr. Alan Newton for a similar reason tendered his resignation and the vacancy was filled by Dr. R. R. Stawell.

### Council Meetings.

There were 22 Ordinary Meetings of the Council and one Special Meeting. The record of attendance is as follows:—

Dr. Davies .. .. 23	Dr. Berry .. .. 13
Dr. Anderson .. 21	Dr. Stephens .. 13
Dr. Hooper .. .. 21	Dr. Kent Hughes* 12
Dr. Crellin .. .. 20	Dr. Jones .. .. 12
Dr. Kenny .. .. 20	Dr. Hiller .. .. 11
Dr. Robertson .. 20	Dr. Wood .. .. 9
Dr. McAdam .. .. 19	Dr. Ostermeyer .. 7

Dr. Mollison .. 19	Dr. Honman† .. 4
Dr. Balfour .. 18	Dr. White .. .. 4
Dr. Lewers .. 18	Dr. Fetherston* .. 2
Dr. Boyd .. .. 14	Dr. Newton* .. 2
Dr. Wilkinson .. 14	Dr. Stawell* .. 2
Dr. Latham* .. 13	Dr. Cumpston .. 1
Representatives of Divisions:—	
Dr. Bonnin .. 0	Dr. Henderson .. 0
Dr. Ffrost .. 0	Dr. Kelly .. .. 1
Dr. Florance .. 0	Dr. Kennedy .. 0
Trustees of Medical Society Hall:—	
Sir Harry Allen .. 0	Dr. Ryan, J. P. .. 0
Dr. Jamieson† .. 0	Dr. Syme‡ .. .. 1
Dr. Ryan, C. S.‡ .. 0	

### Sub-Committees.

The following Sub-Committees were appointed by the Council, the first-named members acting as conveners:—**Organization.**—Drs. McAdam, Crellin, Balfour, Robertson, Ostermeyer, Latham, and Fetherston.

**War Organization.**—Mr. Crouch, Drs. Honman, Boyd, Latham, McAdam, Hooper, and Berry.

**Press.**—Drs. Lewers, Honman, Latham, and Wilkinson.

**Ethical.**—Drs. Kenny, McAdam, Latham, Davies, Balfour.

**Legislative.**—Drs. Newton, Honman, Latham, Crellin, Davies, Ostermeyer, Jones and Cumpston.

**House.**—Drs. Mollison, Anderson and Latham.

**Scientific.**—Drs. Hiller, Newton, Stephens, Lewers, Robertson, with power to add.

Upon the resignation of Dr. Latham Dr. Hooper was appointed to all Committees vacated by Dr. Latham.

### Appointments.

The following appointments were made by the Council:—**Representative on the Central Council.** Dr. W. T. Hayward.

**Representative on the Council of Bush Nursing Association:** Dr. A. V. M. Anderson.

**Representative on Advisory Board to Medical Inspector of Schools:** Dr. H. Douglas Stephens.

**Representative on Free Kindergarten Union of Victoria:** Dr. W. Kent Hughes.

**Representative on Federal Committee—for 1916 (in place of Dr. Latham, resigned):** Mr. G. A. Syme. For 1917: Dr. Boyd and Mr. Syme.

**Victorian Correspondent for the British Medical Journal:** Prof. R. J. A. Berry.

**Representatives on the District Medical Committee:** Drs. Boyd and Syme.

On the nomination of the Council, the Governor-in-Council has been pleased to appoint Mr. G. A. Syme a trustee of the Medical Society Hall in place of Dr. James Jamieson (deceased).

### Membership Roll.

The number of members on the roll is 861, as against 834 of the preceding year. In normal times the increase would have been much greater; a large number of this year's graduates have proceeded direct to military service. During the year there has been a gain of 53 members by election and 5 by transfer from other States. On the other hand we have lost 7 by transfer, 5 by resignation and 14 by death. We regret to have to record the deaths of the following members:—Drs. James Jamieson, Kenneth Maxwell, John P. Montgomery, Charles L. McCarthy, D. McMaster Officer, George O. Rigby, John Small, Thomas Stanton, Charles A. Stewart and William C. Wilkinson, in addition to the four members mentioned below who died on military service.

### War and the Medical Profession.

For the past year much of the work of the Council has been directly or indirectly connected with the continuance of the present war. Two hundred and twelve of our members are on active service abroad or are doing duty in camps or hospitals. Forty-one have returned from active service and twenty-three are on whole-time service in the Commonwealth. Of a total membership roll of 861 members, 276, or a fraction over 32 per cent., have volunteered for service in defence of the Empire. In addition, there is a large body of recent graduates who are receiving six months' hospital training before their services will be called upon by the Defence Department.

\* Members for portion of year only. † Whole-time Military Service.  
‡ Deceased. † Absent from State. ‡ Recently nominated.



In response to a recent appeal by the Director-General of Medical Services many practitioners have joined the Army Medical Reserve and thus have placed their services at the disposal of the Principal Medical Officer whenever he may think it most expedient to call for their services. This constitutes a record of which the profession may justly feel proud.

The end of the war is not yet in view, and the demand for men is still insistent. We deplore the loss of sixteen Victorian medical practitioners in the cause of Empire. Of these nine were members of our Association. In addition to the four mentioned in the last Annual Report—Drs. F. S. Campbell, A. W. H. Langley, G. C. Mathison and Leonard A. Wright—we have to add the names of Drs. E. W. Deane, H. F. Green, F. Miller Johnson, J. G. Mackenzie, and A. Guy Miller. The Council has decided to place an Honour Roll on the walls of the Medical Society Hall bearing the names of all Victorian medical practitioners, whether members of the Association or not. Thus there will be added to the above list the names of Drs. F. S. Bond, J. F. Fairley, G. Howitt, Keith M. Levi, G. P. Merz, A. C. Rothera and E. R. Welch.

To provide as far as possible against any undue dislocation of the civil needs of the community the Defence Department has established a District Medical Committee of six members, two of whom have been nominated by this Council. Sub-Divisional Committees have been formed to ascertain the local medical requirements and to suggest how far the services of medical practitioners in certain districts may be utilized by the military authorities; on their advice the District Medical Committee will act.

The profession is loyally undertaking the work of absent colleagues, and has agreed to restore to them upon their return all appointments and patients. The War Organization Committee has been frequently called upon for its advice in matters concerning the practices of absent medical men and its decisions invariably have been accepted. In many cases it has determined upon what conditions a medical man may commence practice in a district where one or more practitioners are absent on military service. In every case due regard has been paid to the interests of the absentee; and the limitations imposed have been unreservedly accepted.

Our three members on the State Medical Committee of the War Council have been continuously occupied during the year in fulfilling their duties to discharged returned soldiers. In consequence of their recommendations the Council decided to urge the establishment of an Orthopaedic Institute on the lines of those organised by Lieutenant-Colonel Robert Jones in England. A deputation of the Council, which waited on the Principal Medical Officer with this object in view, received a sympathetic hearing.

By the vigilance of the Council pension rights have been assured to those medical men who have enlisted and are engaged in camp duty, but who by a technicality are not yet members of the A.I.F. We are glad to report that the cases of the late Captains Rothera and Langley were satisfactorily adjusted. Other matters that engaged the attention of the Council were the question of the shortage of drugs; the substitutes for drugs of enemy origin; fees payable to medical men for examination of recruits; the employment of fifth year medical students in country hospitals and as locum tenentes.

In this latter case the Council drew attention to the danger involved in the practice, and made it clear that it could only be sanctioned under conditions of extreme urgency.

#### *Work of Sub-Committees.*

By far the greatest amount of preliminary investigation work has been done by the Ethical Committee, and its deliberations have been conducted with great care. The Council feels deeply indebted to Dr. A. L. Kenny, the convener of this Sub-Committee, for his keen judgement, the delicate handling of difficult situations and correctness of expression in which its determinations have been placed before the Council. The members of the Council feel a deep sense of loss now that he has been compelled to retire from the Council because of urgent private matters.

On the recommendation of this Committee the Council has taken steps to discourage the practice of lay newspapers inserting the name of members in connexion with attendance upon patients, and has considered numerous

cases of advertising in the lay press, and its requests for a discontinuance have met with a ready compliance.

The Legislative Committee has been called together frequently to consider drafts of proposed bills and bills already before Parliament. The opinion of the Council was sought by the Minister of Public Health with regard to certain provisions of the Midwives' Bill and of the Venereal Bill. In the latter case by its advice many objectionable features of the Bill have been removed.

It has now under consideration the Nurses' Registration Bill, the Medical Act, and the Opticians' Bill.

Matters in connexion with Lodges have been the chief concern of the Organization Committee. The truce arrived at upon the outbreak of the war has been faithfully observed in the letter and spirit. Representations were made by certain Sub-Divisions that application should be made to the lodges for an increase of fees on the ground that expenses had gone up. These applications were refused, as also were applications for a re-opening of negotiations with the Association of Friendly Societies for the adoption of the Model Lodge Agreement. Notice of motion, which was received at a general meeting, that a referendum should be taken to this effect was negatived by fifty-four votes to four.

It was reported to the Council that some of the Orders, in the case of men on active service, were keeping married men only financial on the doctors' lists; while the single men had been removed from the lists. This would have meant a distinct alteration in the pre-war status. The salary of the medical officer is based on the existence of a certain percentage of picked lives; and attendance on a married man means attendance on an average of four persons. A circular letter was sent to all the Orders of the Friendly Societies pointing out that any member not kept financial on the doctors' list whilst absent on war service would be disentitled to reinstatement without re-examination. Satisfactory replies were received from the majority of the Orders; two of the foremost did not vouchsafe a reply; one alone—the Independent Order of Rechabites—admitted the correctness of the report.

A request by the Council that the Association of Friendly Societies might consider the advisability of issuing uniform medical certificates and so save time and money to themselves and to the medical officers met with a ready acceptance. These certificates will shortly be available.

The work of the War Organization Committee has already been mentioned.

#### *Deputations.*

Three Deputations from the Council have waited upon the Minister of Public Health:—

1. In connexion with the irregular practice of so-called herbalists, etc. Instances had been brought before the Council by the Ballarat Sub-Division where the public health was distinctly endangered owing to the fact that these men were treating notifiable infectious diseases, but were not notifying them to the authorities in the same way as legally qualified medical practitioners were compelled to do. Cases were mentioned where tramcars were daily used by diphtheritic patients and where sweatmeats were vended to children by a girl in an advanced stage of the disease. In each of these cases the patient had died, but the local responsible authorities took no action. In answer to a protest the Minister stated by letter that no offence had been committed under the Act and that, therefore, he was powerless to intervene. The Deputation, which included Drs. Kelly, Morrison, and R. Scott, of Ballarat, asked him to obtain the necessary power by legislation, but this he was disinclined to do, although he personally was against irregular practice in any form.

2. A second deputation waited on the Minister of Public Health to protest against the Opticians' Bill. It was contended that the Bill infringed upon the privileges of the medical practitioners who specialized as oculists; and allowed unqualified persons to undertake functions for which they were not fitted. The deputation called attention to the fact that it had been erroneously stated that this Bill had received the support of the Ophthalmic Section of the Victorian Branch of the British Medical Association. The Bill was subsequently withdrawn.

3. The Venereal Bill, as it left the Legislative Assembly, had several features which the Council of the

Branch sought to have removed. The chief of these was the section carried by the Assembly whereby the Minister was given power under Regulations to fix the maximum fee chargeable for attendance upon all patients suffering from venereal disease. The Minister stated that it was inadvisable for fees to be fixed by regulations which could not be enforced, and that while in office he would not exercise the power. The Bill is still under the consideration of Parliament.

Deputations are to be arranged to advance the scheme for the removal of the Medical School to a site near the Melbourne Hospital; and for the maintenance of the standard of eyesight at present in existence for sea-pilots.

#### Public Hospitals.

The attention of the Council was called to two cases of flagrant abuse of public charity where hospitals receiving a Government grant and participating in public subscriptions were admitting patients who were in a position to pay fees to outside medical practitioners. Such a practice was permitted by the Hospital Committees which sometimes received large fees and were, therefore, reluctant to cut themselves off from such sources of revenue. The object for which public hospitals were established was ignored. The usual declaratory statement was made by patients that they were indigent or were unable to pay fees to outside medical practitioners and, as was stated in one case, the Committee sent out an account for forty-five guineas for a minor operation. Public hospitals have been established for the indigent only and on that ground medical men give their services gratuitously. Such abuse of charity was brought to the notice of the Inspector of Public Charities, whose views on the subject coincided with those of the Council. He promised to report to the Chief Secretary and urge the further establishment of Intermediate Hospitals.

#### Monthly Meetings.

Nine Monthly Meetings have been held at the Medical Society Hall and one Clinical Meeting at the Melbourne Hospital. The following papers were read:—

- Lt.-Colonel H. W. Bryant: "Notes on Difficulties and Trials of Administration of a Field Hospital."
- Lt.-Colonel George Horne: "Experiences with the Australian Voluntary Hospital in France."
- Lt.-Colonel G. A. Syme, Major T. P. Dunhill, and Major B. T. Zwar: "Surgical Experiences at the War."
- Lt.-Colonel J. W. Springthorpe: "Medical Experiences at the War."
- Dr. Sydney Pern: "Some Functions of the Thyroid Gland and their Relationship to Gout."
- Mr. Hamilton Russell: "Treatment of Fractures of the Lower Extremities." Illustrated with limelight views.
- Dr. A. Norman McArthur: "Fibrosis Uteri." Specimens shown.
- Dr. R. H. Morrison: "Salpingitis." Specimens shown.
- Dr. J. F. Wilkinson: "Starvation and Diet in Diabetes."
- Dr. H. Douglas Stephens: "Epidemiology, Pathology and Symptomatology of Anterior Poliomyelitis."
- Dr. A. Jeffreys Wood: "Diagnosis, Prophylaxis and Medical Treatment of Anterior Poliomyelitis."
- Dr. W. Kent Hughes: "Surgical Treatment of Anterior Poliomyelitis." Illustrated by lantern slides.
- Dr. R. R. Stawell: "Recruit's Heart and Soldier's Heart."

At two of the general meetings of the Association resolutions were passed to place on record the Association's sense of loss upon the deaths of Sir Victor Horsley, of London, and Dr. John B. Murphy, of Chicago.

The following showed cases:—Drs. H. Douglas Stephens, J. F. Wilkinson, S. P. Croom, W. R. Boyd, A. S. M. Tymms, Cedric Roche, S. V. Sewell, H. Crawford (for Dr. W. J. Denehy), R. O. Douglas, B. T. Zwar, G. A. Syme, W. Kent Hughes, and S. O. Cowan (for Dr. F. H. Langlands).

On behalf of the Council,

C. STANTON CROUCH,

Secretary.

#### Librarians' Report.

The Librarians have pleasure in presenting the Report for the year ending December 6th, 1916.

Some years ago the principle was adopted that as textbooks were expensive and had a tendency to become out of date rapidly, these should no longer be purchased for the library, but that efforts should be directed towards the establishment of a library of current periodicals. With the discontinuance of the *Australian Medical Journal* there has been a considerable reduction in the number of periodicals received by way of exchange. Further, through stress on the finances of the Branch imposed by the war, the Council has been unable for the present to provide the money to supplement this meagre supply. In order to minimize overlapping by the different libraries in Melbourne, a conference was called and representatives of the Public Library, University Library, Medical School Library and some of its subsections, as well as of the Board of Public Health, attended. None of the representatives was willing to cease subscribing to periodicals which had been taken for many years and in this way break the continuity of the sets. However, satisfactory arrangements were concluded with regard to subscriptions to future journals. The question of cataloguing all the medical literature in Melbourne was deferred, both on account of the expense and because of the fact that there was the possibility of another organization contributing largely in that direction. Lists of new medical publications taken by the different libraries in Melbourne will be published quarterly in *The Medical Journal of Australia*, and in this way future overlapping may be avoided.

Orders for all journals subscribed to by the Branch have been placed directly in the hands of Messrs. H. K. Lewis, of Gower Street, London, and it is hoped by this arrangement the journals will reach the library with greater regularity and punctuality than in the past, and that missing numbers will be more readily replaced.

Repeatedly it has been found that members have, in violation of the rules, removed a number of current literature and inadvertently failed to return it. In this way a whole sequence has been spoilt, and endless delay has been occasioned before the numbers could be bound.

It is hoped that members will see to returning any literature in their possession which is the property of the Branch. They could also assist in completing any sets which have thus been broken.

It may be useful for members to know that there are back numbers of the *Australian Medical Journal*, *The Medical Journal of Australia* and *British Medical Journal*, all classified and readily accessible. From these members can, if they so desire, complete their sets at any time.

By availing ourselves of an offer made by the Library Committee of a United States County Library we have been able to complete many of our broken sets at very little cost.

We would like to call the attention of those of our members who review books for *The Medical Journal of Australia* that such books are the property of the Branch, and should be sent to this library as soon as reviewed. Of one set of eleven books received some time ago for review by members, only two have so far been sent on to the library.

We acknowledge with thanks books and periodicals from the Editor of *The Medical Journal of Australia*; also books from Mrs. Atkinson, of Bendigo; and portion of the Morrison bequest from the University Medical Library.

H. DOUGLAS STEPHENS, } Hon.  
ALLEN ROBERTSON, } Librarians

On the motion that "the annual report be adopted," Dr. B. Rosenberg stated that lodge practitioners were not satisfied with the organization work. The greatest trouble in the future would be the young man coming straight from the University and entering practice without any knowledge of the lodge question, or of the fact that there was such a thing as the model lodge agreement, which was not in operation because of a truce with the lodges. He would not know when he came into a district that he was not allowed to apply to the lodges for an appointment. He should be informed of these things before he spent his money on a practice. The speaker advocated that a notice to this effect should be inserted in the *Speculum*.

Dr. C. Maxwell stated that he had come 30 miles to express his disappointment at the attitude of the 'Organiza-

tion Committee. The truce had been a mistake. He was dissatisfied with the 16s. which he was receiving for lodge work. He had been receiving the same sum for eight years. He had written to the secretaries of three lodges, demanding a 50% rise. The matter should be reconsidered by the Organization Committee, as medical practitioners were paying more for everything they required. He believed that his views coincided with those of the majority of the country members.

Dr. A. N. McArthur spoke in the name of a large number of country members. They were highly disappointed that no strong action had been taken to remedy their appalling position. Lodge practitioners were worked exceedingly hard, and the Victorian Branch had not supported these men in the same manner as they had been supported in New South Wales. He maintained that something had to be done, and that the time for action had arrived. Unionism, he said, must be met forcibly by medical unionism. At the outbreak of the war the matter had been shelved "for the present." He asked whether they should labour under their grievances possibly for 15 years because the war was in existence. He urged that negotiations should be re-opened, in order to avoid the introduction of nationalization of the medical profession, which was the ultimate aim of the Friendly Societies.

The motion for the adoption of the report was put to the meeting and carried.

#### Presidential Address.

Dr. A. V. M. Anderson (the retiring President) made his address (see page 511).

Dr. A. L. Kenny proposed a vote of thanks to the retiring President for his address. He wished to express the appreciation of the members for the way in which he had conducted the affairs of the Branch. He had known Dr. Anderson since his student days and during his later developmental period as a practitioner. He had fulfilled what was desirable in a medical practitioner in the highest degree; he was punctilious in the observance of all that made for good and honourable practice. As a student he had been an earnest seeker after knowledge; in fact, he had never ceased to be a student. Dr. Anderson's facilities had been unique. The speaker recalled a period when typhoid fever had so taxed hospital accommodation that a huge tent had been established at the Alfred Hospital, where invaluable experience had been gained. To remember his relations with his fellow-practitioners brought nothing but pleasing recollections. There was no man he met in consultation with greater pleasure, nor one who showed such intense regard for the interests of the patient. In his presidential office he had shown sound judgement in the numerous problems brought before him. His distinguished services had earned for him the approbation of every member.

Dr. W. R. Boyd seconded the vote of thanks. Dr. Anderson was a worker all the time. The Branch was under a debt of gratitude to him for the work he had done as a member of the Council and as President. Dr. Boyd had been a student at the University with Dr. Anderson in 1882, where he had shown proficiency in athletics, and carried all before him at final honour examinations. As a resident medical officer at the same hospital at which Dr. Anderson held this position he had found him always agreeable, helpful, very energetic and a loyal colleague. It was to be regretted that his year of office should have come during a time of world-wide strife. To those who had stayed at home it had been a year of long hours and continuous work, and he knew that great calls had been made upon the retiring President's time.

The motion was carried with acclamation.

Dr. Anderson thanked the members for their approval of the good things, all too undeserved, that had been said of him.

#### General Business.

Dr. Rosenberg urged the Council to include the item "general business" in the agenda paper of the ordinary meetings of the Branch, in order that members should not have to wait till the end of the year to discuss matters of importance to them. He feared that the truce was the biggest mistake that had ever been made in the history of the Branch. It would determine the rate of pay in any nationalization scheme, just as had happened in England. The

most important part of the work of the Association, in his opinion, was medico-political, and not scientific.

Dr. J. M. Baxter brought under the notice of the President some glaring advertising by members in connexion with the play "Damaged Goods," which was being staged in Melbourne. He regretted that some who had given testimonials were members of the Council. He had received a pamphlet from the Secretary on the subject of advertising, and if the paper had any value he trusted the Council would take steps to have the matter rectified. It was contrary to medical ethics, and demanded immediate attention.

Dr. F. L. Davies said that it was a matter of giving a testimonial to a play run for private profit. The Council had been asked for permission to support this undertaking, and it had refused; nevertheless, its members and others had done so. He had observed that they had all given their addresses as Collins Street. (Laughter.)

The President assured members that the matter would be dealt with at the next Council meeting.

Professor Berry, on behalf of the members, thanked Dr. Anderson for his parting gift, a vertical filing cabinet made of Australian wood. The cabinet, which was much appreciated, would greatly facilitate the work of the Secretary.

The following have been nominated for election to the New South Wales Branch of the British Medical Association:

Dr. Arthur M. Burge, Warren.  
Dr. W. K. Dale, Orange.  
Dr. Gordon W. Bray, Sydney.  
Dr. Pierre A. L. Quessy, Marrickville.

### Naval and Military.

A single and a double list of casualties have been issued on December 11, 1916, and contain in all 1,906 names. Among those reported wounded are Captain M. R. Finlayson, Captain P. E. Voss and Captain F. Boothroyd. The last named has returned to duty.

It has been announced that the Mathison Memorial Committee offered on December 4, 1916, to the Melbourne University Council the sum of approximately £200 to found a triennial memorial lectureship in some medical subject, to perpetuate the memory of the late Dr. G. C. Mathison.

The Principal Medical Officer of the Fourth Military District has forwarded the following notice for publication in *The Medical Journal of Australia*:—

With reference to a military notice which appeared in the press, it is pointed out by the military authorities that the cancellation of the appointment of Captain Hampden Carr does not affect the status of this officer, who still holds his appointment gazetted on April 8, 1911.

In the *Commonwealth of Australia Gazette*, No. 180, dated December 7, 1916, it is announced that Colonel T. A. Fiaschl, D.S.O., V.D., resigned his appointment in the Australian Imperial Force on July 10, 1916.

Honorary Lieutenant R. Purcell Cohen has been promoted to the rank of Honorary Captain in the Australian Army Medical Corps. The gazettal is dated September 1, 1916.

Lieutenant-Colonel A. D. White, V.D., has been appointed Assistant Director of Medical Services, and Major C. E. Wassell has been appointed Deputy Assistant Director of Medical Services. The gazettal of these appointments is dated July 10, 1916.

In District Order No. 156 of the 2nd Military District the following appointments to the District Medical Referee Board have been announced, in accordance with the provisions of Section 75 of the War Service Regulations, 1916: Major J. Kerr, Major G. Read, Captain N. W. Hansard, Captain B. B. Blomfield, Captain E. McCredie, Captain J. W. Gormley, Captain J. K. Osborne, Captain D. Wood, Captain J. O'Flynn, Captain H. H. Monckton, Captain S. W. Hogg, Captain R. A. Lovejoy, Captain I. Aird, Captain C. N. Matheson, Captain H. G. Phippen, Captain J. G. M. Beale, Captain S. Morton, Captain R. Belth, Captain W. K. W. Flook, Captain J. R. Tillett, Captain J. S. Wilson, Captain A. Robertson, Captain J. J. Brennan, Dr. T. O. F. Alsop, Dr. D. Thomas, and Dr. S. H. Hughes.



The following officers of the A.A.M.C. are mentioned in the *Commonwealth Gazette* of November 30, 1916, for distinguished and gallant services rendered during the period of General Sir Charles Monro's Command of the Mediterranean Expeditionary Force:—

Lieutenant-Colonel A. H. Sturdee, C.M.G., V.D.  
 Lieutenant-Colonel C. T. C. de Crespigny.  
 Major G. W. Barber.  
 Major A. Y. Fullerton.  
 Captain E. T. Brennan.  
 Captain A. V. Honman.  
 Captain J. J. Black.  
 Captain (Temporary Major) R. D. Campbell.  
 Captain H. V. P. Conrick.  
 Captain C. W. Thompson.  
 Captain and Quartermaster A. E. Clarke.  
 Honorary Lieutenant F. Marshall.  
 Quartermaster and Honorary Captain E. T. Boddam.

The announcement of the undermentioned appointments appears in the *Commonwealth Gazette* of November 30, 1916:—

To be Major—

Major A. Cock, Staff Officer to Director-General Australian Army Medical Services (temporarily).  
 Dated 1st December, 1916.

To be Major (with pay of Captain)—

Honorary Major A. Grant, V.D., Retired List. Dated 18th October, 1916.

To be Captains—

Major J. A. Goldsmid, Unattached List. Dated 21st October, 1916.

Captain W. K. Inglis, Australian Army Medical Corps. Dated 20th July, 1916.

Captain (provisional) N. B. Watch, Australian Army Medical Corps. Dated 1st November, 1916.

Captain (provisional) K. M. Whiting, Australian Army Medical Corps. Dated 1st October, 1916.

Captain (provisional) D. D. Coutts, Australian Army Medical Corps. Dated 18th November, 1916.

Captain (provisional) A. B. Morris, Australian Army Medical Corps. Dated 15th September, 1916.

Honorary Captain J. Aird, Australian Army Medical Corps Reserve.

Honorary Captain A. R. Southwood, Australian Army Medical Corps Reserve. Dated 10th October, 1916.

Honorary Captain W. R. Page, Australian Army Medical Corps Reserve. Dated 1st September, 1916.

Honorary Captain A. O. V. Tymms, Australian Army Medical Corps Reserve. Dated 1st November, 1916.

Thomas Montague Mansfield. Dated 1st October, 1916.

Hector Llewellyn Beale. Dated 2nd October, 1916.

Geoffrey Penrose Arnold and Raymond James Haynes. Dated 9th October, 1916.

George Milroy Whish. Dated 17th October, 1916.

Francis Brown Craig and Francis Bramall Metcalfe. Dated 18th October, 1916.

Reginald Lancelot Poulton. Dated 19th October, 1916.

Edwyn Mitford Lilley. Dated 20th October, 1916.

William Rock. Dated 23rd October, 1916.

William Keith Walker Flock and Arthur Wellesley Nankervis. Dated 25th October, 1916.

Francis Charles Somerset Adams. Dated 27th October, 1916.

Cecil Roy Quinn. Dated 31st October, 1916.

Thomas Edward Marshall. Dated 1st November, 1916.

Oswald Jacob Ellis. Dated 2nd November, 1916.

Donald Murray Ross. Dated 8th November, 1916.

Adam Gibson Brydon. Dated 11th November, 1916.

To be Honorary Lieutenants—

Gershon Berendt-Bennett. Dated 30th November, 1915. (This cancels the notification respecting this officer which appeared on page 1580 of *Commonwealth of Australia Gazette*, No. 83, of 13th July, 1916.)

Arthur Cabbage. Dated 20th July, 1915. (This cancels the notification respecting this officer which appeared on page 1581 of *Commonwealth of Australia Gazette*, No. 83, of 13th July, 1916.)

William Henry Marshall. Dated 26th January, 1916. (This cancels the notification respecting this officer which appeared on page 1581 of *Commonwealth of Australia Gazette*, No. 83, of 13th July, 1916.)

Captain (temporary Major) T. F. W. Hall, from appointment as Staff Officer, Director-General, Australian Army Medical Services, at £550 per annum, inclusive of all allowances except travelling, to be Staff Officer on Staff of Director-General, Australian Army Medical Services, with pay of rank of Major when actually employed on military duty. Dated 1st January, 1917.

1st Military District.

Australian Army Medical Corps Reserve—

Ronald Maguire Thomson to be Honorary Captain. Dated 1st June, 1916.

William James Gilbert to be Honorary Captain. Dated 14th September, 1916.

James Vivian Church, Christopher Montgomerie Davidson, John Higgins, Alfred Jefferis Turner, Andrew Buchanan Steele, Hugh Thomas Symes Bell, Charles Herbert Clatworthy, Thomas Irby Wallace, Frederic Archibald Hope Michod, and Alfred Eland Shaw to be Honorary Captains. Dated 15th November, 1916.

2nd Military District.

Australian Army Medical Corps Reserve—

George Reginald Percy Hall to be Honorary Captain. Dated 22nd September, 1916.

John Daniel Herlihy, Thomas Walter Lipscomb, and David Christie to be Honorary Captains. Dated 10th October, 1916.

Kenyon St. Vincent Welch to be Honorary Captain. Dated 13th October, 1916.

George William Mason to be Honorary Captain. Dated 14th October, 1916.

Richard Weekes Young to be Honorary Captain. Dated 17th October, 1916.

Percy Dean Bray and Robert Melville Crookston to be Honorary Captains. Dated 19th October, 1916.

Patrick Blackall to be Honorary Captain. Dated 21st October, 1916.

Henry Frank Sadler and Norman Dawson Royle to be Honorary Captains. Dated 23rd October, 1916.

Edwin Claud Chisholm to be Honorary Captain. Dated 25th October, 1916.

St. John Warburton Dansey to be Honorary Captain. Dated 28th October, 1916.

John Inglis Clark Cosh to be Honorary Captain. Dated 31st October, 1916.

Llewellyn William Roberts and William Christian Daish to be Honorary Captains. Dated 1st November, 1916.

Edwin Horace Bottrell to be Honorary Captain. Dated 3rd November, 1916.

Harry Charles Rikard Bell and Wilfred Billingsley Dight to be Honorary Captains. Dated 6th November, 1916.

Paul Clipsham to be Honorary Lieutenant. Dated 30th September, 1915.

George Douglas Donkin and William Harrison Ross to be Honorary Lieutenants. Dated 16th October, 1916.

3rd Military District.

Australian Army Medical Corps Reserve—

Arthur Francis Bell to be Honorary Captain. Dated 12th May, 1915.

William Lookyer Potter to be Honorary Captain. Dated 5th October, 1915.

Crichton Raoul Merrilless to be Honorary Captain. Dated 7th August, 1916.

Walter Freeman Brownell, Arthur Gerald McGowan, James Morison Gardiner, John Patrick Horgan, Alfred Raymond Fox, Gerald Carl Weigall, Ed-

win Archibald Holland, Edward Henry Fyffe, Alexander Sandison, Frank Kingsley Norris, Joseph Joan Connor, Charles Crozier Magee, George Alexander Eadie, Thomas Campbell Ker, Donald McLean, William Alexander Reid, George William Armstrong, Frank Victor Gordon Scholes, John Richards Harris, Charles Fitzmaurice Harkin, Noel Tracey Bull, Augustus Leo Kenny, William Beaumont Heyward, Hugh Stanislaus Bourke, Arthur Augustus Crooks, Andrew Stuart Robertson, Edward Leo Anthony McCardel, Ferguson Augustus Lemon, Harold Rupert Hyett, and Edward Augustus Spowers to be Honorary Captains. Dated 15th November, 1916.

Lieutenant (provisional) B. J. Thompson is transferred from 60th (Brunswick-Carlton) Infantry and to be Honorary Lieutenant. Dated 15th November, 1916.

Lieutenant (provisional) L. B. Cox is transferred from 58th Infantry (Essendon Rifles) to Australian Army Medical Corps Reserve, 4th Military District, and to be Honorary Captain. Dated 4th October, 1916.

#### 4th Military District.

##### Australian Army Medical Corps Reserve—

William Allen Hunter to be Honorary Captain. Dated 6th October, 1916.

Frederic John Chapple, Henry Harper Formby, Charles Nicol MacQuarrie, and Walter Henry Russell to be Honorary Captains. Dated 9th October, 1916.

Laurance Llewellyn Davey to be Honorary Captain. Dated 10th October, 1916.

Charles Thomas Abbott and Owen Meredith Moulden to be Honorary Captains. Dated 12th October, 1916.

Sydney Manton Verco to be Honorary Captain. Dated 13th October, 1916.

James Edward Evarard to be Honorary Captain. Dated 15th October, 1916.

William Blair Aitken and Gordon Roy West to be Honorary Captains. Dated 17th October, 1916.

William Petrie Cormack and Reginald Alfred Goode to be Honorary Captains. Dated 23rd October, 1916.

Frank Gladstone Cowan, Horace Edgar Dunstone and James Milne to be Honorary Captains. Dated 24th October, 1916.

Ferniehrst Halldon Borthwick and Cecil Tanko to be Honorary Captains. Dated 25th October, 1916.

William Alfred Vernon Drew to be Honorary Captain. Dated 26th October, 1916.

Philip Matenson and Harold Fleming Dunstan to be Honorary Captains. Dated 30th October, 1916.

Sydney Letts Dawkins to be Honorary Captain. Dated 2nd November, 1916.

James Atkinson Bonnin to be Honorary Captain. Dated 7th November, 1916.

Lieutenant (provisional) L. B. Cox is transferred from 58th Infantry (Essendon Rifles), 3rd Military District, and to be Honorary Captain. Dated 4th October, 1916.

Rees Norman Campbell to be Honorary Lieutenant. Dated 20th September, 1916.

#### 5th Military District.

##### Australian Army Medical Corps—

Captain R. C. E. Atkinson to be Major. Dated 1st November, 1916.

##### Australian Army Medical Corps Reserve—

David William Hartnell Mackie, James Stephen Macdonald Allan, Charles William Laver, Hubert Baldwin Gill, Rustat Henry Hemsted, Walter Alfred Saunders Bridgeford, Roy Charles Merryweather, James Edward Ramsay, Launce- lot Machell Travers Hungerford, William Edward Blackall, William Saunders Myles, George Johnstone Campbell, Matthew Kasner Moss,

Alfred Webster and Theodore Ambrose to be Honorary Captains. Dated 15th November, 1916. Thomas Alexander Moffat Wilson to be Honorary Lieutenant. Dated 1st November, 1916.

The appointment of the following officers has been terminated:—

Lieutenant-Colonel L. W. Bickle. 12th October, 1916.

Captain D. Dawson. 20th November, 1916.

Captain T. A. Grieves. 5th November, 1916.

Captain F. Howson. 19th November, 1916.

Captain W. C. Medlyn. 6th November, 1916.

Honorary Major O. J. Lawson. 30th October, 1916.

## Public Health.

### THE HEALTH OF NEW SOUTH WALES.

The following notifications have been received by the Department of Public Health, New South Wales, during the week ending December 2, 1916:—

	Metropolitan District.	Hunter River District.	Rest of State.	Total.
	Cs. Dths.	Cs. Dths.	Cs. Dths.	Cs. Dths.
Enteric Fever ..	16 0 ..	4 0 ..	10 0 ..	30 0
Scarlatina ..	63 1 ..	5 0 ..	24 0 ..	92 1
Diphtheria ..	26 0 ..	2 0 ..	28 1 ..	56 1
C'bro-Sp'l Menin.	5 4 ..	0 0 ..	5 1 ..	10 5
Poliomyelitis ..	1 0 ..	0 0 ..	0 0 ..	1 0
*Pul. Tuberculosis	30 14 ..	1 0 ..	0 0 ..	31 14
Malaria ..	1 0 ..	0 0 ..	0 0 ..	1 0

\* Notifiable only in the Metropolitan and Hunter River Districts, and, since October 2, 1916, in the Blue Mountain Shire and Katoomba Municipality.

### THE HEALTH OF VICTORIA.

The following notifications have been received by the Department of Public Health, Victoria, during the week ending December 3, 1916:—

	Metropolitan.	Rest of State.	Total.
	Cs. Dths.	Cs. Dths.	Cs. Dths.
Diphtheria ..	59 4 ..	25 1 ..	84 5
Scarlatina ..	17 0 ..	14 0 ..	31 0
Enteric Fever..	1 0 ..	3 2 ..	4 2
Pulmonary Tuberculosis	14 8 ..	12 3 ..	26 11
C'bro-Spinal Meningitis	4 — ..	3 — ..	7 —

### INFECTIVE DISEASES IN QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, during the week ending December 2, 1916:—

Disease.	No. of Cases.
Erysipelas ..	2
Pulmonary Tuberculosis ..	6
Diphtheria ..	36
Scarlatina ..	9
Enteric Fever..	23
Ankylostomiasis ..	1
Malaria ..	1

### THE HEALTH OF SOUTH AUSTRALIA.

The following notifications have been received by the Central Board of Health, South Australia, during the week ending November 25, 1916:—

	Adelaide.	Rest of State.	Total.
	Cs. Dths.	Cs. Dths.	Cs. Dths.
Morbili ..	4 0 ..	63 0 ..	67 0
Pertussis ..	7 1 ..	48 1 ..	55 2
Diphtheria ..	6 1 ..	20 0 ..	26 1
Pulmonary Tuberculosis	1 2 ..	15 5 ..	16 7
Scarlatina ..	0 0 ..	2 0 ..	2 0
Enteric Fever..	1 0 ..	6 0 ..	7 0
C'bro-Spinal Meningitis	0 0 ..	1 0 ..	1 0
Erysipelas ..	0 0 ..	3 0 ..	3 0

## INFECTIVE DISEASES IN WESTERN AUSTRALIA

The following notifications have been received by the Department of Public Health, Western Australia, for the week ending November 25, 1916:—

Disease.	Metro- politan. Cases.	Rest of State. Cases.	Totals. Cases.
Enteric Fever...	3	2	5
Diphtheria ..	9	4	13
Scarlatina ..	0	1	1
Pulmonary Tuberculosis ..	4	3	7
Cerebro-Spinal Meningitis...	2	2	4

## THE HEALTH OF TASMANIA.

The following notifications have been received by the Department of Public Health, Tasmania, during the week ending December 2, 1916:—

Disease.	Hobart. Cases.	Launceston. Cases.	Country. Cases.	Whole State. Cases.
Diphtheria ..	2	2	8	12
Pulmonary Tuberculosis	0	1	4	5
C'bro-Spinal Meningitis	2	2	1	5
Puerperal Fever ..	0	0	1	1

## INFECTIVE DISEASES.

Bulletin No. 17 has been issued by the Quarantine Department on November 24, 1916. It contains the following information.

## Variola.

Australia continues to be free from variola. Since the issue of the last bulletin there have been 51 cases and 12 deaths recorded in the Dutch East Indies. A bill of health dealing with the week ending November 2, 1916, has been issued in Hong Kong, and contains information concerning six cases and five deaths.

## Plague.

The number of cases of plague in India during the week ending October 7, 1916, was 6,107, and in the same period there were 4,507 deaths. There were 16 cases in Ceylon between October 1 and October 14, 1916. In Java, eight cases were reported between October 7 and October 20, with seven deaths. There were three cases, but no deaths, between September 15 and October 5, 1916, in Egypt. One case and two deaths were reported during the week ending November 16, 1916, in the Straits Settlement.

## Cholera.

The latest returns from the Dutch East Indies deal with 41 cases of cholera and 13 deaths. There were 15 cases of the same disease, with three deaths, between October 29 and November 11, 1916, in the Philippine Islands.

## Typhus Fever.

The following table is reproduced from the public health reports issued by the United States Public Service:—  
(For period 30th September to 6th October, 1916.)

Place.	Cases.	Deaths.
Austria-Hungary ..	1	—
Belgium ..	—	1
China ..	1	—
Egypt ..	111	51
Germany ..	3	3
Great Britain ..	1	1
Greece ..	—	29
Mexico ..	106*	—
Switzerland ..	1	—
Turkey in Asia ..	3	1

\* Estimated.

## Vital Statistics.

## SOUTH AUSTRALIA.

The returns dealing with the births and deaths registered in South Australia during the month of October, 1916, have been issued from the Chief Secretary's office on November

17, 1916. The statistics are based on an estimated population of 439,660.

During the month of October there were 978 births, and during the first ten months of the year there were 10,091 births. The number of births is somewhat lower than the average for the corresponding month in the previous five years. The birth-rate is equivalent to an annual birth-rate of 26.76. In October, 1913, the rate was equivalent to an annual rate of 29.58, while in October, 1915, it was as low as 24.96. It is regrettable that the published figures do not include further details in regard to the variations in the birth-rate, and that no mention is made of the proportion of nuptial to ex-nuptial births. The number of deaths registered in October, 1916, was 379. Of these, 47 were of infants under one year of age, and 35 of children between one and five years of age. There were 115 individuals between 60 and 80 years of age at the time of death, and 41 over 80. In 23 cases a coroner's enquiry into the cause of death was held. The death-rate works out at an equivalent to an annual rate of 10.32 per 1,000 of population. This rate is lower than the average for October in the period from 1911 to 1916. The infantile mortality rate is 48 per 1,000 births.

There were 80 deaths due to diseases of the cardio-vascular system, including 53 from organic diseases of the heart and 15 from cerebral hæmorrhage. Of the infective diseases, tuberculosis caused 45 deaths, pneumonia caused 25, diarrhoea and enteritis caused 12, bronchitis caused 11, diphtheria caused 10, meningitis caused 7, pertussis caused 7, enteric fever, morbilli, influenza and acute rheumatism caused two each, and scarlatina and acute nephritis caused one each. There were 29 deaths from malignant disease and 16 from Bright's disease. There were four deaths in the category of puerperal conditions, including one from septicæmia.

The returns for the city of Adelaide show that there were 101 births during the month, 56 being of males and 45 of females. The birth-rate is therefore equivalent to an annual rate of 27.72. The deaths numbered 68, 39 being of males and 29 of females. In this return the deaths occurring in public institutions of persons not usually resident in the city are not included. The corrected death-rate for the city of Adelaide is equivalent to an annual rate of 18.6. The Registrar-General appends a table giving the causes of the 68 deaths. The numbers are too small to be of importance from the point of view of incidence of disease.

## University Intelligence.

## THE UNIVERSITY OF SYDNEY.

A meeting of the Senate of the University of Sydney was held on December 4, 1916, at the University.

The degree of Bachelor of Laws was conferred upon Mr. P. E. Summers and Mr. P. Vivian.

On the recommendation of the Dean of the Faculty of Law it was resolved (i.) that the application of Mr. E. M. Mitchell, Lecturer in Law, for leave of absence for military service be granted, and (ii.) that Mr. D. S. Edwards be appointed locum tenens.

The following examiners in Law for 1917 were appointed on the recommendation of the Dean of the Faculty of Law: The Professor of Law, the Lecturers in Law and Mr. N. G. S. Pilcher, B.A., LL.B.

On the recommendation of Professor Irvine, Mr. F. B. Guthrie was re-appointed Lecturer in the Technology of Commercial Products.

On the recommendation of the Professor of Agriculture, the following alterations in the by-laws of the curriculum in the Department of Agriculture were adopted:—

Section 3. Candidates for the degree of Bachelor of Science in Agriculture shall, during the first year, attend the courses of instruction upon and pass the examinations in the following subjects: (1) Chemistry I, including laboratory practice; (2) Botany I, including laboratory practice; (3) Zoology I, including laboratory practice; (4) Geology I, including laboratory practice; (5) Physics I. (part course).

Section 4. Candidates for the degree of Bachelor of Science in Agriculture shall, during the second year, attend the course of instruction upon and pass the



examinations in the following subjects: (1) Chemistry (Organic and Physical), with laboratory practice; (2) Botany (Systematic and Physiological), with laboratory practice; (3) Agricultural Geology, with laboratory practice; (4) Principles of Agriculture I, with laboratory practice; (5) Economic Entomology.

On the recommendation of the University Extension Board, the board was re-appointed as follows:—

*Ex Officio Members:* The Chancellor, the Vice-Chancellor, and the Warden and Registrar.

*Members of the Senate:* His Honour Judge Backhouse, M.A., Messrs. H. C. L. Anderson, M.A., J. Nangle and R. Teece, F.I.A.

*Members of the Teaching Staff:* Professor M. W. MacCallum, M.A. (Chairman), Professors T. W. Edgeworth David, C.M.G., B.A., D.Sc., F.R.S., R. F. Irvine, M.A., G. Arnold Wood, M.A., and W. J. Woodhouse, M.A., Assistant Professor E. R. Holme, M.A., and Mr. Meredith Atkinson.

*Unofficial Members:* The Rev. Principal A. Harper, M.A., D.D., Messrs. H. Y. Braddon, E. S. Edwards, M.A., E. B. Taylor and J. M. Taylor, M.A., LL.B.

*Secretary:* Assistant Professor F. A. Todd, B.A., Ph.D.

## Correspondence.

### ENLISTMENT OF DOCTORS IN THE RESERVE.

Sir,—Before further appealing to every medical man in Australia to apply for a commission in the Australian Army Medical Corps Reserve, you ought to be made aware of the attitude of the Defence Department towards a large and useful class of medical men—those over 60 years of age.

On receipt of the Surgeon-General's appeal, I promptly sent in an application, which was promptly turned down, because I was over 60. I am in active practice as a general practitioner and hospital surgeon in a country town, but have the misfortune to be in my sixty-second year.

Yours, etc.,

M.D., C.M., M.A.

[Our correspondent would have saved himself his trouble had he referred to the memorandum of the Director-General of Medical Services on the organization of the medical profession which was published in *The Medical Journal of Australia* of October 7, 1916, pages 306-7. In the paragraph dealing with doctors over 45, the sentence begins: "The Government earnestly hopes that all medical men between the ages of 45 and 60 . . ." In our repeated references to this pamphlet and in our appeal to medical men to apply for a commission in the Australian Army Medical Corps Reserve we assumed that our readers would have recognized the limitation which has been placed on volunteers, and which also obtained in connexion with the enlistment of men in the Citizen Forces, as provided for by the Defence Act, 1903-1915, and the War Precautions Act, 1914-1916. We are sure that the authorities, as well as his colleagues, will esteem our correspondent all the more because he has offered his services, notwithstanding the fact that he has passed the age limit.]

### CANCER IN THE INSANE.

Sir,—Year after year the report of the Inspector-General of Insane for Victoria shows that the death-rate for cancer among the insane is considerably less than that of the general population. Speaking in round figures, a study of over 4,000 consecutive deaths of the Victorian insane shows that the proportion of the death-rate from cancer is under 4%. These cases extend over a period of 11 years—from 1905 to 1915 inclusive.

During the years 1905 to 1914 inclusive the cancer proportion of the death-rate in Victoria was slightly over 7%. (The figures for this period were kindly supplied me by the Victorian Government Statist.)

To me it appears that the insane have a relative immunity, and when other factors are taken into consideration the position is much more favourable to them. Thus the cancer

rate for the general population includes all deaths, and hence is favourably influenced by the great number of children and others dying before what may be regarded as the cancer period. Ninety-one per cent. of our patients are over the age of 25 years, and about 40% are between the ages of 40 and 55. Further, in about 90% of deaths in our institutions the cause of death is determined by post-mortem examination, so that the margin of our error is extremely small. This does not hold good for the ordinary vital statistics.

The figures quoted are small, but extremely suggestive. I am of opinion that cancer is twice as common outside the hospitals for insane. If this opinion be correct, the matter is worth pursuing further, and perhaps it is not asking too much to suggest that the medical officers of the insane hospitals in the various States should consult their post-mortem records, in order to verify or controvert my figures. I should be glad of any information on the subject.

Yours, etc.,

J. CATARINICH,

Acting Medical Superintendent.

Hospital for Insane, Beechworth.

(Undated.)

### PROVOCATIVE SALVARSAN INJECTIONS.

Dr. G. S. Thompson writes to enquire when a positive reaction occurs after a provocative salvarsan injection, and how long this positive reaction lasts. Towards the end of 1910 Jennerich, of Kiel (*Med. Klinik*, October 10, 1910), and Millan, of Paris (*Société de Dermatologie*, December 1, 1910), independently introduced the practice of stimulating the body to produce antibodies necessary for the fixation of complement in the Wassermann reaction. In discussing this so-called provocative reaction, P. Ehrlich wrote in November, 1911, that its theory was that minute remains of spirochaetes, which did not suffice to effect a positive Wassermann reaction, would be brought into solution by an injection of salvarsan. The liberated spirochaetal protein gave rise to a temporary power of the serum to fix complement. Ehrlich found that the maximum liberation occurred between 10 and 14 days after the injection. This method has been utilized by a large number of observers since that time, and general experience has demonstrated that the reaction becomes positive in a majority of cases 48 hours after the injection. McDonagh speaks of a delay of from 7 to 14 days; but it is probable that the reactive process usually begins on the second day, and is not completed until the lapse of from two to three weeks. Under these circumstances, it is advisable to carry out the Wassermann test 48 hours after the injection, and if it be still negative, to repeat the test after 14 days.

### HYDROCYANIC ACID FUMIGATION.

Sir,—Dr. Corlette's very interesting paper on fumigation of ships prompts me to suggest that Dr. Corlette give us some further information re the effects of hydrocyanic acid fumigation on bacterial life. If the bactericidal effect of hydrocyanic acid fumigation be anything like its insecticidal effect, it should be particularly useful in military work, and would be much less expensive than the formalin method at present used.

Yours, etc.,

W. J. BEVERIDGE, M.D.

Albany, Western Australia,  
November 22, 1916.

[As far as we are aware, hydrocyanic acid vapour has not been used for the purpose of destroying bacteria. The extreme toxicity of the substance and the technical difficulty of applying it as a disinfectant are bars to its general use. Dr. Corlette informs us that a few trials have been made to determine its action on fungi. Hitchcock and Corleton immersed the uredospores of *Puccinia graminis* in a 0.1% and a 0.01% solution of hydrocyanic acid. The stronger solution prevented germination, while the weaker had no effect. These data are cited by E. Bourcart.]

## Proceedings of the Australasian Medical Boards.

### VICTORIA.

The following have been registered under the provisions of "The Medical Act, 1915," as duly qualified medical practitioners:—

Park, Roy Lindsay, M.B., et Ch.B., Melb., 1916.  
Cox, Leonard Bell, M.B., et Ch.B., Melb., 1916.  
Lawrence, Robert Wreyford, M.B., et Ch.B., Melb., 1916.  
Additional Registration.  
Franklands, Herbert William, D.P.H., 1915.

### TASMANIA.

The following have been registered under the provisions of "The Medical Act, 1908," as duly qualified practitioners:—

Pryde, Alan, M.B., B.S., Melb., 1914.  
Waterhouse, Arthur Robert, M.B., B.S., Melb., 1916.  
Kerr, Joshua Law, M.B., Aberd., 1880, C.M., Aberd., 1880, M.D., Aberd., 1890.

## Births, Marriages, and Deaths.

The charge for inserting advertisements of Births, Marriages and Deaths is 5s., which sum should be forwarded in money orders or stamps with the notice, not later than the first post on Tuesday morning, in order to ensure insertion in the current issue.

### DEATH.

**WOLFHAGEN.**—On December 1, 1916, at 61 St. George's Terrace, Hobart, of meningitis, Minnie, the beloved wife of J. E. Wolfhagen, M.B., C.M., Edin.

## Medical Appointments.

The New South Wales *Gazette* of December 8, 1916, contains the following appointments of Inspectors under Section 50 of the "Cattle Slaughtering and Diseased Animals and Meat Act, 1912": Dr. Francis Frederick Brown, Government Medical Officer, Bourke; Dr. Terence Aubrey Daly, Government Medical Officer, Cumnock.

The Board of Governors of the Public Library, Museum and Art Gallery of South Australia contains two medical men, namely, Dr. Richard Sanders Rogers, who has been appointed by his Excellency the Governor, and Professor E. C. Stirling, C.M.G., who has been elected by the University of Adelaide.

## Medical Appointments.

### IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

#### Branch.

#### APPOINTMENTS.

**VICTORIA.**  
(Hon. Sec., Medical Society Hall, East Melbourne.)

Brunswick Medical Institute.  
Bendigo Medical Institute.  
Prahran United F.S. Dispensary.  
Australian Prudential Association Proprietary, Limited.  
National Provident Association.  
Life Insurance Company of Australia, Limited.  
Mutual National Provident Club.

#### Branch. SOUTH AUSTRALIA.

(Hon. Sec., 3 North Terrace, Adelaide.)

#### QUEENSLAND.

(Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)

#### WESTERN AUSTRALIA.

(Hon. Sec., 230 St. George's Terrace, Perth.)

### APPOINTMENTS.

The F.S. Medical Assoc., Incorp. Adelaide.

Brisbane United F.S. Institute.

Swan District Medical Officer.  
All Contract Practice Appointments in Western Australia.

Department of Public Instruction—Appointments as Salaried Medical Officers, with duties which include the treatment of school children.

Australian Natives' Association.  
Balmain United F.S. Dispensary.  
Canterbury United F.S. Dispensary.  
Leichhardt and Petersham Dispensary.  
M.U. Oddfellows' Med. Inst., Elizabeth Street, Sydney.

Marrickville United F.S. Dispensary.  
N.S.W. Ambulance Association and Transport Brigade.

North Sydney United F.S.  
People's Prudential Benefit Society.  
Phoenix Mutual Provident Society.

F.S. Lodges at Casino.  
F.S. Lodges at Lithgow.  
F.S. Lodges at Orange.  
F.S. Lodges at Parramatta, Penrith, Auburn, and Lidcombe.

Newcastle Collieries—Killingworth.  
Seaham Nos. 1 and 2, West Wallsend.

#### NEW ZEALAND: WELLINGTON DIVISION.

(Hon. Sec., Wellington.)

F.S. Lodges, Wellington, N.Z.

## Diary for the Month.

Dec. 19.—N.S.W. Branch, B.M.A., Medical Politics Committee.

Dec. 21.—City Med. Assoc. (N.S.W.).

Dec. 22.—Q. Branch, B.M.A., Council.

1917.

Jan. 9.—N.S.W. Branch, B.M.A., Council (Quarterly).

Jan. 16.—N.S.W. Branch, B.M.A., Executive and Finance Committee.

### EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.

All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney, New South Wales.